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Ohio Medicine

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Guidelines for managing chronic pain are included in the OSMA's new handbook, *Pain – The Fifth Vital Sign*, scheduled to be mailed to all Ohio physicians later this month.



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Legislative hot topics for 1999 will undoubtedly include HMO accountability, rampant pay and prescriptive authority for nurses, among other topics.

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To avoid charges of fraud and abuse, your office should have a compliance plan, complete with a mission statement and a plan for handling system failures.

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Optometrists want to expand their formulary to include oral agents. This is the second time the Optometry Board has asked to add drugs to its prescriptive authority.

Need the legal facts?
Legal fact sheets covering a variety of topics are available on the OSMA Web site at www.osma.org

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Pain handbook mails this month

Pain – *The Fifth Vital Sign*, the handbook developed by the OSMA on the subject of pain management, will be mailed this month to all Ohio physicians.

The handbook is a guide to the management of chronic, intractable pain, and was developed by the OSMA Ad Hoc Committee on Pain Education after a legislative mandate calling for more pain control education. The OSMA agreed to develop and mail a handbook, not only because of the importance of the issue, but also because, in return, the Legislature

agreed to drop language from the bill that would have required all Ohio physicians to obtain two hours of CME credit on pain management.

The handbook will be distributed to all Ohio physicians this month, and should be in your hands soon. It will offer two hours of Category I CME. The printing and mailing of the handbook was supported by an unrestricted grant from the Roxane Institute.

The pain control legislation (Senate Bill 187) that required the education of physicians on managing chronic pain also required the State Medical

Board of Ohio to adopt rules establishing standards and procedures for physicians in the diagnosis and treatment of intractable pain. Those rules became effective Nov. 11. ■

Take Action

If you have not received *Pain – The Fifth Vital Sign* by the end of the month, contact the OSMA Department of Communications, (800) 766-6762. You will be sent a copy.

Medical Board wants OSMA support in \$30 fee increase

The State Medical Board of Ohio is proposing a \$30 license fee increase, to become effective during the biennium beginning Jan. 1, 2000.

The board last raised license fees in 1996. At that time, the \$30 increase was supported by the OSMA.

In November, Ray Albert, the medical board's consumer member, and board staff member Tom Dilling presented the proposed fee increase to the OSMA Council, seeking, once again, the association's support.

OSMA Councilors raised questions during the presentation about the need and use for the additional money, but finally voted to not oppose the board's proposal.

Medical board members will continue to seek support for the fee increase proposal from other profession-

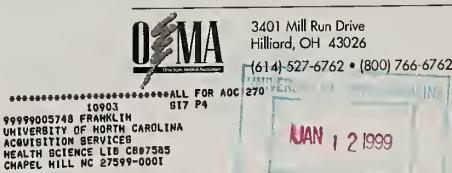
OSMA, Cleveland Academy reach agreement

As a result of a productive mediation session, the OSMA and the Academy of Medicine of Cleveland have reached an agreement that resolves a dispute between the two affiliated physician groups. The settlement will reinstate the academy as a component society of the OSMA and, in return, the academy will drop its pending lawsuit against its parent organization.

In addition to reinstating the academy as the OSMA local component society and dismissing the lawsuit, the settlement also terminates the OSMA's plans to activate a new affiliate society in Cuyahoga County.

OSMA President Lance Talmage, MD, said, "We are pleased that this matter has been resolved to each party's satisfaction. Now, the OSMA and the academy can continue to serve as the unified voice for the physicians in Cuyahoga County and better address the significant health-care related issues that confront us."

For more information contact, Doug Evans, director of Membership Services at (800) 766-6762, Ext. 6774 e-mail: devans@osma.org. ■





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Med Board...

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al associations. According to Nick Lashutka, associate director of the OSMA Department of Legislation, the board will have to submit its proposal to the Taft Administration for placement in the state budget bill. That bill must be approved by July 1, 1999. Support from the state's professional associations will improve the chances that the board's proposal will be included in the budget bill before it's drafted. ■

OSMA Annual Meeting format streamlined

The new shorter, more streamlined meeting format adopted during last year's Ohio State Medical Association's Annual Meeting will be continued this year in Cincinnati May 14-16.

The Opening Session will start at 10 a.m. Saturday and include the installation of David J. Utak, MD, as the new OSMA President. Resolution committee hearings will be held from 1:30-5 p.m. followed by district caucuses if needed. The remainder of Saturday will be spent preparing resolutions reports and conducting candidate interviews. The evening will conclude with a presidential reception.

District caucuses will meet Sunday morning prior to the 10 a.m. Final Session of the House of Delegates.

For those interested in attending the Organized Medical Staff Section Meeting, it will be held on Friday, May 14 from 1-4 p.m.

Resolution deadline is midnight March 15. Resolutions must be mailed to the Executive Director, Brent Mulgrew, Ohio State Medical Association, 3401 Mill Run Drive, Hilliard, OH 43026.

For more information contact Susan Paulus, Annual Meeting coordinator, (800) 766-6762, Ext. 6727.

For a complete schedule, visit the OSMA Web site at www.osma.org. ■

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Bills, Laws & Rules

The legislative year in review

Medicine accomplished much during the 1997-1998 legislative session. During that time, state lawmakers considered 82 different health-care proposals – 18 of which were ultimately enacted. Subjects ranged from managed care and insurance market reform to regulating tattooing and body piercing services.

What follows is a look back at the OSMA's legislative achievements last session and, in a related story, a look at the legislation that may be in organized medicine's future.

The year's highlight: Managed-care reform

The bill: House Bill 361 PHPPA (Physician-Health Plan Partnership Act)

Managed-care reform in Ohio became possible through House Bill 361, the Physician-Health Plan Partnership Act. The new law establishes minimum operating standards for managed-care plans in the state, and is, arguably, the first comprehensive bill of its kind in the country. Expect this bill to help restore balance in the managed-care environment.

Features:

- Establishes corrective action rights for physicians prior to being terminated from a health plan.
- Creates a defined, standardized process for resolution of adverse utilization review decisions.
 - Prohibits gag rules.
 - Mandates use of a standardized credentialing form.
 - Provides for physician input into the development of medical management issues.
 - Allows patients with chronic conditions to have a standing referral to a specialist.
 - Gives patients access to nonformulary drugs under certain circumstances.

OSMA's role: The OSMA developed the Physician-Health Plan Partnership Act, in cooperation with Kaiser Permanente and engineered the proposal through the state Legislature.

For physician-entrepreneurs

The bill: Senate Bill 67 MCULA (Managed-Care Uniform Licensure Act)

When the Ohio Department of Insurance proposed setting solvency standards for HMOs, they initially tried to license and regulate "Provider-Sponsored Organizations" (PSOs) under the same regulatory scheme as traditional HMOs. That would have meant that physicians who wanted to enter the insurance marketplace would have had to meet the same re-

serve requirements as HMOs.

OSMA's role: The OSMA fought to ensure that new regulations for PSOs did not create a barrier for physicians entering the insurance marketplace – and the association was successful in persuading legislators to create a separate regulatory structure for PSOs (with lower solvency standards than HMOs). The new law should now provide physicians with opportunities to form their own provider-sponsored insurance networks if they choose.

Clinical autonomy assured

The bill: Senate Bill 31

Although Ohio still arguably has a ban on the corporate practice of medicine, there are situations in the marketplace where physicians are employed by hospitals and HMOs. Senate Bill 31 was introduced as a means of allowing limited license practitioners and physicians to combine a business practice for the purpose of carrying out their respective professions.

OSMA's role: The OSMA worked to include in the bill specific clinical autonomy protections for physicians who are in these new business relationships with limited license practitioners. Thanks to organized medicine, the ability of Ohio physicians to make individual medical treatment decisions based on their professional clinical judgment is now protected by law.

Safe harbor created for pain treatment

The bill: House Bill 187

This bill establishes standards for physicians when treating intractable pain and administering controlled substances, and establishes a safe harbor for them, when they treat pain within established protocols. The State Medical Board of Ohio was given the responsibility of establishing new pain rules.

OSMA's role: The OSMA has assumed an educational function, teaching physicians more about pain management. Initially, the pain control bill would have required physicians to complete a content specific CME on pain control, but the OSMA was successful in having this provision removed. In return, the OSMA agreed to develop a CME handbook on the subject of intractable pain. It will be mailed to all Ohio physicians this month.

What's hot in 1999?

Late last year, the OSMA surveyed its membership, asking for help in setting legislative priorities for the year ahead. Response cards were included in informational packets sent regarding the Physician-Health Plan Partnership Act. Members were asked to indicate where they stood on a particular issue, and how they rated the subject in terms of legislative priorities. The results have been tabulated.

Here they are:

1. HMO accountability

Make managed-care plans liable for denial decisions that result in patient harm.

For: 98.2%

Against: 1.8%

2. Prompt pay

Mandate that plans reimburse more promptly.

For: 100%

Against: 0%

3. Advanced Practice Nurses

Grant APNs the right to prescribe schedule II-IV drugs

For: 9.8%

Against: 90.2%

4. Independent external review

Require independent review for certain adverse UR decisions once internal review is exhausted.

For: 93%

Against: 7%

5. Mental health parity

Prohibit insurance companies from discriminating in coverage of mental health issues.

For: 91.8%

Against: 8.2%

6. Medical director licensure

Require that medical directors of plans be licensed by the state medical board.

For: 95.9%

Against: 4.1%

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Legal review

What you should know about restricted licenses

When it comes to who may not be issued a driver's license in Ohio (due to a driving impairment) the law identifies:

- Those who suffer from a physical or mental disability or disease that "prevents exercising reasonable and ordinary control" over a motor vehicle;
- Epileptics; and
- Those addicted to alcohol or controlled substances.

Currently, no state statute requires you to report a patient's driving impairment to the Bureau of Motor Vehicles (BMV) – however, you might be asked for your professional input by either the registrar of Motor Vehicles or by the patient.

Restricted licenses

In order to receive a restricted license, for example, the applicant must have been subject to a condition resulting in episodic impairment of consciousness or loss of muscular control; and the applicant's condition must now, in the opinion of the registrar, be dormant or sufficiently under medical control.

That's where you come in. A restricted license will be issued when the applicant presents a statement from a licensed physician that states the condition is under effective medical control and the period of time for which the control has been continuously maintained.

Annual licenses

Once a restricted license has expired, the applicant may then be issued an annual license, as long as his or her condition remains dormant or under effective medical control. The annual license, however, may be renewed for no more than three consecutive years. Again, the applicant will need to present a signed statement from a licensed physician stating that:

- 1. The condition is either dormant

or under effective medical control;

- 2. The control has been maintained continuously for at least one year, prior to the date on which application for the license is made; and

- 3. If continued medication is prescribed to control the condition, the person may be depended upon to take the medication.

If you are completing a statement for a patient who meets this criteria, the statement must be presented on a form provided by the registrar, must be in duplicate, and must contain any other information the registrar considers necessary. No medical examination, prior to submitting the signed statement, is required – however, if the registrar believes the condition has returned, or that the person is no longer capable of safe operation of a motor vehicle, the applicant will be told to obtain a signed medical report from a licensed physician. This report must be returned to the registrar within 20 days from the date of the exam, for evaluation by the BMV. The registrar has discretion in deciding whether or not to issue the restricted license.

Your liability

So far, there is nothing in Ohio case law to support the concept of physician liability for nonreporting, but you should exercise some caution in your statement to the registrar.

According to *Krejci v. Akron Pediatric Neurology, Inc.*, a physician has a duty to determine, within reasonable medical certainty, that the patient's condition is, in fact, under effective medical control – and that duty extends to a third person injured by the patient. Therefore, even if you won't be held liable for not reporting the patient's impairment, you may be liable for any negligence you displayed in certifying that a patient's condition was medically controlled when, in fact, it was not.

Ethical obligation

Finally, you need to consider your ethical obligations when deciding whether or not to report a driving impairment. The current policy of the American Medical Association (AMA) recommends that "the physician, if uncertain about the patient's ability to drive, consider recommending that the state licensing agency arrange a driving test."

The AMA's Council on Ethical and Judicial Affairs in Current Opinion 5.05 adds the following:

"The information disclosed to a physician during the course of the relationship between physician and patient is confidential to the greatest possible degree...The obligation to safeguard patient confidences is subject to certain exceptions that are ethically and legally justified because of overriding social considerations.

Under Ohio law, a physician can be disciplined by the State Medical Board of Ohio for violating AMA ethical principles. ■

Take Action

If you have specific questions concerning impaired drivers, you should refer them to an attorney familiar with this area of the law. The information for this article came from the OSMA Legal Fact Sheet on Driving Impairment. For a complete copy of this fact sheet, check out the OSMA Web site, www.osma.org. (Look under "hot news.") Or you may contact the Ohio Medicine reader response line, (800) 766-6762, Ext. 6580, and ask for item #1-99.

Survey...

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7. Hospital employment
Allow hospitals to directly employ physicians.

For: 49.8%
Against: 50.2%

8. Tobacco
Raise the purchase age for cigarettes to 21.

For: 85.3%
Against: 14.7%

9. Telemedicine
Require all physicians who practice through electronic means from outside the state to be licensed in Ohio.

For: 84%
Against: 16%

10. Trauma system
Create a state trauma network, i.e. only hospitals designated as trauma centers would treat the most seriously injured.

For: 67.4%
Against: 32.6%

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How to set up a compliance plan

The OSMA does not provide a standard compliance plan, but will talk to physicians about what are the essential elements of a compliance plan.

"The criminal penalties that can be visited upon physicians these days are horrendous for false claims, fraud and abuse, or other violations of federal law," warns Patricia Jacobson, a partner at Porter, Wright, Morris & Arthur. To protect yourself and your practice, Jacobson suggests you develop a written policy for complying with your obligations as a Medicare provider.

A compliance plan has several elements, including:

- **Mission statement or code of conduct.** A concise statement of principle about the actions your practice takes to detect, deter, and discipline for violations.

- **Policies and procedures.** How you monitor your contracts and billing procedures and conduct internal audits. You're responsible even if someone else made the mistake.

- **Policy for handling external investigations.** What to do if a Medicare investigator or, worse, an inspector general or Justice Department investigator shows up in your office.

- **Plan for handling failures in the system.** How you handle a physician who refuses to follow regulations. How you handle a billing clerk who does you the "favor" of upcoding.

Appoint a compliance officer

Also required is a compliance officer, someone everybody in your office trusts. No particular training is required, but your compliance officer must have a clean criminal record and an aversion to cutting corners. You should also provide some confidential mechanism that allows employees to report suspected violations or improper practices.

Before creating your compliance plan, do a retrospective audit. "Figure out how you stack up in terms of com-

pliance with billing regulations," Jacobson says. "Analyze what kinds of contracts you have with other providers to make sure they comply with various laws. Once you discover where you might have problems, then you can address those problems in a forward-looking plan."

To be considered effective, a compliance plan must be specific to your practice. "It does more harm," says Katrina English, former director of the Division of Legal Affairs, "to have an off-the-shelf compliance plan that hasn't been tailored for your practice or implemented for your staff. That's more dangerous than not having one at all."

No standard document available

Although any law or accounting firm can offer you starter documents, the OSMA does not, English says. "We debated the issue of providing a standard compliance plan but decided that would be a disservice to members who might think that was all they needed. What we can do is talk to them about what are the essential elements of a compliance plan and refer them to professionals who can help them get one that is appropriate and specifically tailored to their practice setting."

Although penalties for Medicare violations follow strict federal guidelines, an effective compliance plan mitigates those penalties. "The Federal Sentencing Guidelines state that if you have a compliance plan that you designed and that you tried to implement, the judge is obliged to minimize the penalties against you," Jacobson says.

"This is a great way to clean your own house, get control of how your office functions as a business in this legal environment, and generally position yourself for future deals with other providers and for dealing with possible investigations." — *Ian Leibovitz Alroy*



Appoint a compliance officer for your office, someone everyone in your office trusts.

To Take Action

For more information, contact Patricio Jacobson, Porter, Wright, Morris & Arthur, (800) 824-1980, or the OSMA Division of Legal Affairs, (800) 766-6762.

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Rural hospitals closer to "employing" physicians

Rural hospitals have been working to pass a law allowing the hiring of staff physicians Senate Bill 239, which would remove the last vestiges of the corporate practice of medicine prohibition that has been in Ohio law for years, passed the Ohio Senate late in the legislative session. Because the Legislature has adjourned, the proposal won't become law.

It is expected the bill will be reintroduced this year and if enacted, hospitals in counties with fewer than 125,000 inhabitants would be able to employ physicians directly. Many hospitals employ physicians today, but must do so through various legal maneuvers.

The legislation received mixed reviews by OSMA members in a recent legislative survey. According to survey results, 49.8% of member supported the bill; 50.2% were against.

Through OSMA's legislative efforts, there is now language in the proposal that protects the physician's professional clinical judgment, with respect to patient care.

Sponsor: Sen. Doug White (R-Manchester)

OSMA position: Under Advisement

For more information: Contact Krista Bistline, Department of Legislation, (800) 766-6762, Ext. 6748, e-mail: bistline@osma.org. ■

Take Action

If you are interested in learning which bills passed both the House and the Senate during the 1997-1998 session, contact the *Ohio Medicine* reader response line, (800) 766-6762, Ext. 6580, and ask for item #2-99. Or go to the Legislation section on the OSMA Web site, www.osmo.org.

Tobacco settlement will help educational efforts

Ohio could gain as much as \$200 million a year for at least 25 years, thanks to the state's settlement with tobacco companies over a lawsuit, filed last year, that charges the tobacco companies with suppressing the truth concerning the health hazards of smoking and using tobacco.

Ohio is among 42 states involved in class-action litigation against the tobacco companies. In addition, the draft agreement prohibits:

- Tobacco companies from opposing state or local laws intended to limit youth access and consumption.

- Sales to youth by using cartoon characters and sponsoring events with a young audience.

- All outdoor tobacco advertising.

- Third parties from using tobacco brand names.

- Naming future cigarette brands after celebrities, sports teams, trade names, etc.

The proposed settlement also requires the industry to create a \$1.45 billion national public education fund.

No one has said yet how the money Ohio receives will be spent. Funds will be allocated by legislators and the governor.

Gov. Bob Taft has said he supports using the funds for cancer-prevention programs, and expanding the Children's Health Insurance Program. Attorney General Betty Montgomery says, she will recommend that a significant portion of the funds be spent for public health programs, and House Speaker Jo Ann Davidson (R-Reynoldsburg) suggests a good portion of the money go to youth-oriented no-smoking programs. ■

Quick news...

Pre-school vision screening needed... Alice Epitropoulos, MD, a Columbus ophthalmologist testified on behalf of the Ohio Ophthalmological Society in support of House Bill 756, the Eye Health Fund bill. According to Dr. Epitropoulos, two of every 10 pre-school children do not have a visual screening test before entering kindergarten, yet one in every 20 children have a visual disorder that will lead to permanent visual problems. HB 756 was amended into another measure that will become law early this year.

Duty-to-warn bill supported... OSMA member and psychiatrist Howard Sokolov, MD, Worthington, testified in support of House Bill 719, the legislation that would clarify when mental health professionals should warn third parties about threats of potentially violent behavior from their clients. The bill is sponsored by Rep. Rose Vesper (R-New Richmond), and is actively supported by the OSMA. It is expected to be reintroduced in 1999.

Alternative medicine bill introduced... House Bill 772 which would allow physicians to use alternative medical treatments if the risk of harm to the patient is reasonable when compared to the potential benefit died at the end of the legislative session and is expected to be reintroduced in 1999. The bill's sponsor, Rep. George Terwilliger (R-Maineville) says interest in alternative medicine is growing daily and his legislation is a simple proposal that will allow physicians to use alternative therapies if the patient and physician agree.

MSA, board measures passed in Senate... House Bill 212, which adds a Medical Savings Account option to the health-care benefits of certain state employees, and House Bill 606, legislation that makes revisions in the disciplinary procedures used by the State Medical Board, (as well as other changes) have both passed the Ohio Senate and are on their way to becoming laws.

ODI files rules that would help prevent insurance insolvencies... The Ohio Department of Insurance had trouble passing a law that would alert it to insurance company insolvencies, so the department has filed rules with a legislative committee to accomplish the same objective. If approved, the rules state that the actuary preparing an insurer's annual audited financial reports must include a report on areas that could present problems. These audit reports would be inspected by the ODI, alerting them early to any potential trouble.

Heart cath moratorium extended... The existing moratorium on the construction of new cardiac catheterization labs without an on-site, open-heart surgery service has been extended an additional six months. Sen. Grace Drake (R-Solon) had wanted to extend the moratorium by two years, noting that not enough data has been collected to determine the safety of low-risk labs without on-site, open-heart surgical backup. The expanded moratorium includes a provision requiring the Ohio Department of Health to update legislators on its progress in collecting statewide and national data on the outcome of cardiac catheterizations performed in facilities without surgical backup. That report will be due Oct. 1. The moratorium was to have ended May 1. Now, rules will not have to be submitted by ODH until Nov. 1. The OSMA expressed concerns over the longer extension.

Optometrists seek to expand formulary

The State Medical Board of Ohio's Minimal Standards of Care Committee is concerned about a move by the Optometry Board to expand its formulary to include oral agents. Specifically, optometrists want to add to their drug arsenal: Allegra, Augmentin, Claritin, Famvir, Ultram, Valtrex, Zithromax, Zovirax, and Zyrtec.

The committee reviewed the list and reported that, although Allegra, Claritin and Zyrtec could be added to the formulary without causing undue concern, the other drugs are inappropriate for use by optometrists.

Deciding what goes on to the Optometry Board's formulary list is not the jurisdiction of the medical board, however, and board members are aware of how carefully this situation must be handled.

The Optometry Board needs only the Pharmacy Board's approval to add to its formulary list. The medical board has no official input into the process unless, as one board member pointed out, the formulary expansion could be construed as the practice of medicine.

Since the initial legislation was passed, allowing optometrists to prescribe drugs, this will mark the second time that optometrists have asked to add drugs to their formulary. Optometrists now have the antiviral drug amoxycillin on its list, for example, as well as some nonsteriodals. According to board members, the optometrists' new request is a repeat of many of the drugs they have requested in the past but for which they have failed, so far, to gain the Pharmacy Board's approval.

Still, the Optometry Board has been careful to follow provisions in the law that require licensees to report bad reactions to the drugs they prescribe. These are kept on a quarterly basis, in a professional manner, and that may influence the Pharmacy Board's decision on whether or not to grant optometrists their expanded formulary list.

Several members of the State Medical Board, including the chair of the Prescribing Committee, hope to meet with the Optometry Board to discuss

Medical Board Report

medicine's concerns with expanding the formulary, especially to certain drugs. *Ohio Medicine* will keep you posted on the progress of this issue as it develops.

Of note...

Misunderstandings arise over late renewal notice...If you were one of the approximately 6,000 licensees to receive a notice from the medical board that you have not yet renewed your license, consider it a favor, says the board. Prior to this year, licensees were not sent such reminder letters and instead, simply found themselves without a license as a result of their tardiness in filing a renewal application. As a courtesy, the board sent the renewal notice, but in the eyes of many who received the letter, the board's actions came too late. They complained they had to pay the \$25 late fee for a tardy license renewal, and said the board should have notified them before the late fee became necessary. Although the board only sent the reminder letters as a final warning to a licensee that he or she was about to lose a license, the board said the staff may look at the timing of the mailing during the next renewal period to see if notices can be sent before the \$25 late fee is charged. Your best bet, however, is to learn when you must file your license renewal application — then meet that deadline.

Managed-care committee discusses de-selection of physicians without DEA certificates...Members representing the medical board met recently with the Ohio Association of Health Plans (OAHP) to discuss, among other points, the de-selection of physicians who do not have, or who no longer hold, DEA certificates from managed-care panels. DEA certificates

are sometimes surrendered by licensees who abuse drugs, as a condition of their rehabilitation agreement with the medical board. According to the OAHP, physicians are de-selected on an individual basis, and for a variety of reasons, not just because they may no longer hold DEA certificates. The OAHP has expressed interest in maintaining a relationship with the board's managed-care committee, so other managed-care issues brought to the board's attention may be the focus of further discussions between the two groups.

Board frowns on Internet prescribing...The Pharmacy Board recently shared a letter with the board's prescribing committee from Pfizer Company on the Internet prescribing of Viagra. Apparently, there are some Internet sites where individuals can call in information, and someone arranges for a prescription to be issued

to these individuals. The prescribing committee discussed its concerns about this practice with the executive director of the Pharmacy Board, who responded that, if the pharmacy board knows of the site, it contacts them to cease and desist. The medical board is concerned about physicians who prescribe drugs, on the Internet or elsewhere, without seeing the patient and keeping a patient record. A medical board member noted that Propecia is another product that is being sold over the Internet. ■

Take Action

If you have questions pertaining to the State Medical Board of Ohio, you may contact Kole Hunter in the OSMA Division of Legal Affairs at (800) 766-6762, Ext. 6766.

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Dateline Ohio

Nurses consult with defense attorneys on medical malpractice

Nurses who serve as consultants for defense attorneys in medical malpractice trials are becoming more popular. Some serve as independent consultants, others, like two Cincinnati registered nurses, have formed their own businesses.

The nurses advise local lawyers on medical aspects of potential personal injury and medical malpractice cases. The job allows them to work from

home and on flexible schedules, earning about \$65 an hour.

The nurses' medical expertise helps to level the playing field for defense lawyers who feel "outgunned" by plaintiff attorneys who, typically, have access to doctors, nurses, and hospital officials. Nurses also claim that, by reviewing records, looking for deviations from appropriate standards of care, they can prevent some malprac-

tice cases from going to trial.

In an article in the *Cincinnati Enquirer*, Carol Jorgensen, RN, an independent consultant for defense attorneys says: "You have to be forthright with the attorneys and tell them if they are wasting their time. You have to tell them if there is no way they are going to win the case." ■

House calls becoming popular again

A joint program between Cuyahoga Falls General Hospital's community home care and its family practice residency program is taking more residents out of the hospital setting and into the homes of elderly, homebound patients.

The program's director, Leroy LeFever, MD, takes a different resident with him on home visits each week. In addition to returning to a more personalized form of medicine, Dr. LeFever says he is afraid if family doctors don't include house calls as part of their practice, the work will be taken over by commercial institutions.

Or by groups like the Visiting Physicians Association (VPA), a company that began in Michigan in 1993 and has recently opened seven offices in Ohio, including offices in Dayton, Columbus, Toledo, Cleveland, Akron, Cincinnati and Youngstown.

House calls make up the entirety of this group's practice. Typically, a doctor and medical assistant visit the patient's home, equipped with blood-pressure cuff, portable cardiac monitor and blood-collecting equipment. The for-profit company pays doctors by the hour and keeps overhead costs low, while billing Medicare and Medicaid for medical exams and diagnostic tests. VPA teams visit 8-15 patients a day. Doctors are usually family practitioners, general internists and geriatric specialists. ■

Inaugural events scheduled

Physicians who wish to participate in inauguration events of Bob Taft as governor of Ohio should contact Krista Bistline, OSMA Department of Legislation, (800) 766-6762, Ext. 6748.

Jan. 10 — Ohio Family Celebration includes a Statehouse tour and educational programs on Ohio government and the office of the governor. The event will be from 1-5 p.m.

Jan. 11 — Official swearing in and inaugural address will take place 11:30 a.m.-1:15 p.m. on the west steps of the Statehouse. In case of bad weather, the event will be held in the Ohio Theatre.

Jan. 11 — Inaugural balls and parties are ticketed events, from 8 p.m.-midnight, at locations around downtown Columbus. Some of the events require black tie. Call Krista Bistline for details. ■

Ohio doctor pleased with breast reconstruction provision

Ohio State Medical Association member Christine Homer-Taylor, MD, Cincinnati, took up a campaign four years ago seeking federal and state legislation requiring insurance companies to pay for breast reconstruction following mastectomy. For Dr. Homer-Taylor, the motivation was personal. As a plastic surgeon, she had breast cancer patients who needed reconstructive surgery and couldn't afford it. Then she watched her mother die of breast cancer.

Her crusade ends successfully, however, as the federal budget bill — including the required benefit she sought — takes effect Jan. 1.

In an article in the *Cincinnati Enquirer*, Dr. Homer-Taylor notes she worked hard for this achievement, meeting with President and Hillary Clinton, Sens. Edward Kennedy and Alfonse D'Amato, and Rep. Sue Kelly. The passage of federal legislation requiring payment for breast reconstruc-



Legislation requiring insurance companies to pay for breast reconstruction following a mastectomy becomes effective Jan. 1.

tion is a "dream come true," says Dr. Homer-Taylor. ■



Making house calls



Patients' rights bill should be in hands of doctor, patient

To the Editor:

The failure of the Clinton administration to successfully pass a Patient Bill of Rights during the last session of Congress should cause us to stop and carefully reassess the elements of this piece of legislation.

No one can deny the fact that quality and access to health care are primary goals. Nevertheless, when decisions on medical management become matters to be taken up by the courts and/or the legislators, I believe all of us as patients will, in the end, suffer. Decisions as to the care to be rendered should be in the hands of the physician and the patient involved in the process.

I believe much discussion and debate should take place in this regard to allow all sides to be heard, and to examine the long-term implications inherent in all versions of the proposed legislation.

Consumers of health care and physicians should be searching for common ground on these and other related issues. To leave this to others will only lead to political and legislative "deal-making." Courts will be, ultimately, making "laws" and establishing precedents that will once more be manipulated by unscrupulous plaintiff attorneys without regard for the welfare of the patient in question.

Organized medicine should step forward and take a leadership role in providing a forum for dialogue on these issues.

I would welcome additional support of this proposal.

Thomas N. Detesco, MD
Boardman

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RATING THE MALPRACTICE CARRIERS

January 1999

The developing medical malpractice marketplace has created increased interest in financial strength ratings, according to Standard and Poor's (S&P) rating service.

Lately, competition has become fierce. The medical malpractice niche is one of the few still-profitable markets within the otherwise soft property/casualty industry, making it attractive again to the larger carriers. There are several reasons for this, says S&P:

1.) The severity of malpractice claims has receded, along with the decline in medical inflation;

2.) Shifting from the occurrence policy model (insuring all procedures done in a given year) to the claims model (insuring against all claims filed in a given year) has produced more accurate pricing, boosting profits;

3.) Managed care has reduced the severity of claims by instituting new processes, practices and monitoring procedures. And, because commercial insurers are more likely than doctors' mutuals to opt for settlement over litigation, their ultimate legal costs are often lower.

New laws can affect rates or spark a flood of competitors. To compete more effectively, both mutuals and smaller companies are pushing for further growth through joint ventures or outright mergers, and expanding into neighboring states. Companies that offer "one-stop shopping," ranging from errors-and-omissions to workers' compensation, have a value-added edge, even if the less-familiar products are handled by reinsurers.

Premiums fell 3.9% during 1997, as increased competition and the economies of scale achieved from the continued shift toward managed care restrained pricing. However, the 100 largest malpractice insurers saw a modest 3.4% increase in premiums, capturing market share at the expense of smaller competitors.

Greater competition is putting pressure on pricing. The industry generally is overcapitalized, while profits remain strong. According to S&P, the needs of an insurer to meet the challenges of the evolving market and to retain customers are even more important than the need for current capital. With competition on the rise, it's crucial to pick an insurer with good future prospects.

Quarterly ratings published by OSMA

The enclosed ratings of selected insurance companies that write medical malpractice insurance coverage in Ohio is the second of a quarterly report.

You are encouraged to check the ratings of your own insurance carrier, or of those you're considering using, more frequently. For OSMA members, hyperlinks are provided from the OSMA Web site (www.osma.org) to the three rating services. Additional contact information for current ratings and research reports is provided within this insert.

The companies represented here are chosen by two means, and are coded by asterisks. One group includes the 16 top-ranked Ohio medical malpractice insurance companies by dollar volume of Ohio premiums written in

1997, according to the Ohio Department of Insurance. The other group includes *Ohio Medicine* advertisers, or companies represented by insurance agencies that are *Ohio Medicine* advertisers.

For additional industry and ratings-insert background, see the October 1998 issue of *Ohio Medicine*, or call OSMA for a copy. The ratings reported in each chart are reprinted with permission from the rating services indicated, and do not reflect OSMA's independent evaluation of the companies listed.
—Carol Larimer

IS YOUR INSURANCE COMPANY ON THIS LIST? CHECK RATINGS INSIDE

- American Continental Ins.
- American International Ins.
- Chicago Insurance Co.
- Cincinnati Insurance Co.
- Continental Casualty Co.
- The Doctors' Co.
- Evanston Insurance Co.
- Frontier Insurance Co.
- Gulf Insurance Co.
- Health Care Indemnity Inc.
- Kentucky Medical Ins. Co.
- Medical Protective Co.
- Medical Inter-Insurance Exchange of NJ
- Mutual Assurance Inc.
- National Union Fire Ins. Co. of Pittsburgh, PA
- OHIC Insurance Co.
- PHICO Insurance Co.
- ProNational Insurance Co.
- St. Paul Fire & Marine Ins. Co.
- St. Paul Mercury Ins. Co.
- Transportation Ins. Co.
- Zurich American Ins. Co. of IL

Selected insurance companies that write medical malpractice insurance coverage in Ohio	NAIC Code	A.M. Best Rating	A.M. Best Date	S&P Rating	Weiss Rating
American Continental Ins. Co.	J2246	A g	12/15/97	Api	C
American International Insurance Co. **	32220	A++ g	8/20/98	AAA	B-
Chicago Insurance Co. *	22810	A p	5/26/98	Api	B-
Cincinnati Insurance Co. (The)*	10677	A++ g	5/18/98	AA+	A
Continental Casualty Co., * member of CNA Insurance ***	20443	A p	9/29/97	A+	C+
Doctors' Co., an Inter- insurance Exchange (The) * ***	34495	A g	5/4/98	BBBpi	A-
Evanston Insurance Co. **	35378	A p	11/17/97	A+	C-
Frontier Insurance Co. * ***	34266	A- g	11/9/98	A+	C+
Gulf Insurance Co. *	22217	A+ p	6/8/98	AA	B
Health Care Indemnity Inc. *	35904	A-	2/23/98	BBBpi	not rated
Kentucky Medical Ins. Co. * ***	38105	A- r	8/31/98	A+	C
Medical Protective Co. * ***	11843	A	11/17/97	AA	B-
Medical Inter-Insurance Exchange of NJ * ***	34398	A	2/23/98	BBBpi	B-
Mutual Assurance Inc. * ***	33391	A g	6/15/98	A+	B
National Union Fire Insur- ance Co. of Pittsburgh, PA ***	19445	A++ g	8/20/98	AAA	B+
OHIC Insurance Co. * ***	35602	A-	4/27/98	A	C+
PHICO Insurance Co. * ***	35718	A- g	11/23/98	BBBq	C
ProNational Insurance Co. *** (a merger of PICOM Insurance Co. & PPTF, effective 7/98)	38954	A- g	3/16/98	A-	C

Selected insurance companies that write medical malpractice insurance coverage in Ohio	NAIC Code	A.M. Best Rating	A.M. Best Date	S&P Rating	Weiss Rating
St. Paul Fire & Marine Insurance Co. ***	24767	A+ p	11/16/98	AA	B+
St. Paul Mercury Insurance Co. ***	24791	A+ r	11/16/98	AA	B
Transportation Insurance Co. *	20494	A p	9/29/97	A+	C+
Zurich American Insurance Co. of IL **	27855	A+ p	9/28/98	AA+	C+

* : a company that is one of the 16 top-ranked Ohio medical malpractice insurance companies by dollar value of Ohio premiums written in 1997. Source: Ohio Department of Insurance

** : an *Ohio Medicine* advertiser, or, a company represented by an insurance agency that is an *Ohio Medicine* advertiser (as reported by that agency)

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Weiss Safety Rating Scale

A = Excellent; **B** = Good; **C** = Fair; **D** = Weak; **E** = Very Weak; **F** = Failed

What Our Ratings Mean

A Excellent. The company offers excellent financial security. It has maintained a conservative stance in its investment strategies, business operations and underwriting commitments. While the financial position of any company is subject to change, we believe that this company has the resources necessary to deal with severe economic conditions.

B Good. The company offers good financial security and has the resources to deal with a variety of adverse economic conditions. It comfortably exceeds the minimum levels for all of our rating criteria and is likely to remain healthy for the near future. However, in the event of a severe recession or major financial crisis, we feel that this assessment should be reviewed to make sure that the firm is still maintaining adequate financial strength.

C Fair. The company offers fair financial security and is currently stable. But during an economic downturn or other financial pressures, we feel it may encounter difficulties in maintaining its financial stability.

D Weak. The company currently demonstrates what we consider to be significant weaknesses which could negatively impact policyholders. In an unfavorable economic environment, these weaknesses could be magnified.

E Very Weak. The company currently demonstrates what we consider to be significant weaknesses and has also failed some of the basic tests that we use to identify fiscal stability. Therefore, even in a favorable economic environment, it is our opinion that policyholders could incur significant risks.

F Failed. The company is under the supervision of state insurance commissioners.

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Weiss Safety Ratings are available by phone only, using a major credit card: \$15 for one company; \$36 for three. Call-in hours are Mon.-Fri.: 8:30 a.m. to 10:30 p.m.; Sat.: 9 a.m. to 5 p.m. Call (800) 289-9222 for ratings.

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order a rating: secure site, requires a credit card:
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Standard & Poor's

home page: www.ratings.com
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CURRENT GUIDE TO BEST'S RATINGS

March 30, 1998

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A.M. Best assigns to insurance companies one of two types of rating opinions, a Best's Rating (A++ to F) or a Financial Performance Rating (9 to 1). The Best's Rating represents an opinion based on a comprehensive quantitative and qualitative evaluation of a company's financial strength, operating performance and market profile. The FPR represents an opinion based primarily on a quantitative evaluation of a company's financial strength and operating performance. Best's Ratings and FPRs provide an independent opinion of an insurance company's ability to meet its obligations to policyholders. For additional information, refer to the Preface.

Secure Best's Ratings

A++ and A+	Superior
A and A-	Excellent
B++ and B+	Very Good

Vulnerable Best's Ratings

B and B-	Fair
C++ and C+	Marginal
C and C-	Weak
D	Poor
E	Under Regulatory Supervision
F	In Liquidation
S	Rating Suspended

Secure FPR Ratings

FPR 9	Very Strong
FPR 8 and 7	Strong
FPR 6 and 5	Good

Vulnerable FPR Ratings

FPR 4	Fair
FPR 3	Marginal
FPR 2	Weak
FPR 1	Poor

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Rating Modifiers are assigned to Best's Ratings and Financial Performance Ratings to identify companies whose rating opinions are Under Review (u) and may be subject to near-term change, or are based on a Group (g), Pooling (p) or Reinsurance (r) affiliation with other insurers. For additional information, refer to the Preface.

g - Group

p - Pooled

r - Reinsured

u - Under Review

NOT RATED CATEGORIES (NR)

Companies not assigned a Best's Rating or FPR are assigned to one of five NR categories which identifies the primary reason a rating opinion was not assigned to the company. For additional information, refer to the Preface.

NR-1	Insufficient Data
NR-2	Insufficient Size and/or Operating Experience
NR-3	Rating Procedure Inapplicable

NR-4	Company Request
NR-5	Not Formally Followed

FINANCIAL SIZE CATEGORIES (FSC)

Assigned to all companies and reflects their size based on their capital, surplus and conditional reserve funds in millions of U.S. dollars, using the scale below. For additional information, refer to the Preface.

FSC I less than 1	FSC V 10 to 25	FSC IX 250 to 500	FSC XIII 1,250 to 1,500
FSC II 1 to 2	FSC VI 25 to 50	FSC X 500 to 750	FSC XIV 1,500 to 2,000
FSC III 2 to 5	FSC VII 50 to 100	FSC XI 750 to 1,000	FSC XV greater than 2,000
FSC IV 5 to 10	FSC VIII 100 to 250	FSC XII 1,000 to 1,250	

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The Insurance Information Source

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A Standard & Poor's Insurer Financial Strength Rating is a current opinion of the financial security characteristics of an insurance organization with respect to its ability to pay under its insurance policies and contracts in accordance with their terms. This opinion is not specific to any particular policy or contract, nor does it address the suitability of a particular policy or contract for a specific purpose or purchaser. Furthermore, the opinion does not take into account deductibles, surrender or cancellation penalties, timeliness of payment, nor the likelihood of the use of a defense such as fraud to deny claims. For organizations with cross-border or multinational operations, including those conducted by subsidiaries or branch offices, the ratings do not take into account potential that may exist for foreign exchange restrictions to prevent financial obligations from being met.

Insurer Financial Strength Ratings are based on information furnished by rated organizations or obtained by Standard & Poor's from other sources it considers reliable. Standard & Poor's does not perform an audit in connection with any rating and may on occasion rely on unaudited financial information. Ratings may be changed, suspended, or withdrawn as a result of changes in, or unavailability of such information or based on other circumstances.

Insurer Financial Strength Ratings do not refer to an organization's ability to meet nonpolicy (i.e. debt) obligations. Assignment of ratings to debts issued by insurers or to debt issues that are fully or partially supported by insurance policies, contracts, or guarantees is a separate process from the determination of Insurer Financial Strength Ratings, and follows procedures consistent with issue credit rating definitions and practices. Insurer Financial Strength Ratings are not a recommendation to purchase or discontinue any policy or contract issued by an insurer or to buy, hold, or sell any security issued by an insurer. A rating is not a guaranty of an insurer's financial strength or security.

Insurer Financial Strength Ratings

An insurer rated 'BBB' or higher is regarded as having financial security characteristics that outweigh any vulnerabilities, and is highly likely to have the ability to meet financial commitments.

AAA

An insurer rated 'AAA' has EXTREMELY STRONG financial security characteristics. 'AAA' is the highest Insurer Financial Strength Rating assigned by Standard & Poor's.

AA

An insurer rated 'AA' has VERY STRONG financial security characteristics, differing only slightly from those rated higher.

A

An insurer rated 'A' has STRONG financial security characteristics, but is somewhat more likely to be affected by adverse business conditions than are insurers with higher ratings.

BBB

An insurer rated 'BBB' has GOOD financial security characteristics, but is more likely to be affected by adverse business conditions than are higher rated insurers.

An insurer rated 'BB' or lower is regarded as having vulnerable characteristics that may outweigh its strengths. 'BB' indicates the least degree of vulnerability within the range; 'CC' the highest.

BB

An insurer rated 'BB' has MARGINAL financial security characteristics. Positive attributes exist, but adverse business conditions could lead to insufficient ability to meet financial commitments.

B

An insurer rated 'B' has WEAK financial security characteristics. Adverse business conditions will likely impair its ability to meet financial commitments.

CCC

An insurer rated 'CCC' has VERY WEAK financial security characteristics, and is dependent on favorable business conditions to meet financial commitments.

CC

An insurer rated 'CC' has EXTREMELY WEAK financial security characteristics and is likely not to meet some of its financial commitments.

R

An insurer rated 'R' has experienced a REGULATORY ACTION regarding solvency. The rating does not apply to insurers subject only to nonfinancial actions such as market conduct violations.

NR

An insurer designated 'NR' is NOT RATED, which implies no opinion about the insurer's financial security.

Plus (+) or minus (-) signs following ratings from 'AA' to 'CCC' show relative standing within the major rating categories.

CreditWatch highlights the potential direction of a rating, focusing on identifiable events and short-term trends that cause ratings to be placed under special surveillance by Standard & Poor's. The events may include mergers, recapitalizations, voter referenda, regulatory actions, or anticipated operating developments. Ratings appear on CreditWatch when such an event or a deviation from an expected trend occurs and additional information is needed to evaluate the rating. A listing, however, does not mean a rating change is inevitable, and whenever possible, a range of alternative ratings will be shown. CreditWatch is not intended to include all ratings under review, and rating changes may occur without the ratings having first appeared on CreditWatch. The "positive" designation means that a rating may be raised; "negative" means that a rating may be lowered; "developing" means that a rating may be raised, lowered or affirmed.

'pi' Ratings, denoted with a 'pi' subscript, are Insurer Financial Strength Ratings based on an analysis of published financial information and additional information in the public domain. They do not reflect in-depth meetings with an insurer's management nor do they incorporate material non-public information, and are therefore based on less comprehensive information than ratings without a 'pi' subscript. 'pi' ratings are reviewed annually based on a new year's financial statements, but may be reviewed on an interim basis if a major event that may affect an insurer's financial security occurs. 'pi' ratings are not modified with '+' or '-' designations, nor are they subject to potential CreditWatch listings.

National Scale Ratings, denoted with a prefix such as 'mx' (Mexico) or 'ra' (Argentina), assess an insurer's financial security relative to other insurers in its home market. For more information, refer to the separate definitions for national scale ratings.

Quantitative Ratings, denoted with a 'q' subscript, were discontinued in 1997. The ratings were based solely on quantitative analysis of publicly available financial data.

OSMA News



The CME Advantage

CME availability is enhanced through accreditation

In many disciplines of medicine, the fast pace of technical changes equates to a high demand from practitioners to get the latest information on diagnostics and treatment.

Thanks to the continuing efforts of the OSMA, an increasing number of local institutions can provide CME that provides that latest information. As the only CME accreditation body in the state of Ohio, the OSMA has accredited more than 70 sponsors. "The advantage here is that OSMA can accredit institutions and organizations on the local level, thus facilitating CME offerings that are pertinent to local medical needs often resulting in a savings of time and money for participating physicians," says Janet Shaw, OSMA director of Continuing Education and Outcomes Research. As a result, hospitals, large group practices and even specialty societies can qualify as CME

sponsors and provide practice-based, patient-related educational activities to their constituencies.

"In addition, providing CME at the local level assures ample opportunities for physicians in Ohio to obtain the necessary CME that is required for licensure," says Albert N. May, MD, chair of the OSMA Committee on Accreditation of CME Sponsors. Without local-accredited sponsors, some physicians might find it difficult to meet the CME requirements. In addition, to provide maximum variety and value to CME programs, Dr. May notes that in addition to hospitals and clinics, numerous "nontraditional" type organizations have qualified with OSMA to sponsor educational programs and now provide such services on a regular basis. Examples include the OHA: The Association for Hospitals and Health Systems and the Ohio Association of

Health Plans.

CME, as defined by the American Medical Association (AMA) standards, must be of high quality, meet participants' educational needs while maintaining certain educational standards. By supporting those goals within Ohio, the OSMA assures physicians that accredited CME programs provide a well-balanced variety of educational experiences. Such experiences can include patient care review conferences, hands-on skill workshops, panel discussions and/or classroom-style, didactic lectures. According to the AMA standards, Category 1 CME are formalized educational activities developed by accredited sponsors. Category 2 encompasses activities not necessarily aligned with an accredited sponsor, such as self-instruction, reading articles and medical teaching, among others. The AMA's Physician Recognition Award (PRA) structure for successful participation in CME programs provides a way to demonstrate fulfillment of license or certification requirements.

The OSMA can assist your local educational source, first through accreditation, then through assistance developing high quality CME programs. "We understand the importance of having outstanding CME opportunities easily accessible to local physicians and want to do whatever we can to facilitate this process," says Shaw.

Having uniform criteria to assess CME programs, the OSMA legitimizes CME as an integral aspect of the medical profession. To CME participants, the benefit of OSMA accreditation enhance program relevance, increase the quality of local presentations, and increase the physician performance in the optimum care and management of patients. — Yvonne Burry

Getting accredited

A recent survey conducted by the OSMA revealed that slightly less than half of the OSMA member respondents were aware that the OSMA serves as the accrediting body for CME in Ohio. As such, OSMA measures the ability of institutions and other entities to plan effective CME activities and maintain an overall CME program in accordance with standards set by the Accreditation Council for Continuing Medical Education (ACCME) and that meet the criteria for CME as defined by the American Medical Association.

CME accreditation pertains only to organizations, institutions and provider entities. Once an entity is accredited, it can then develop educational activities such as seminars, conferences, and written educational materials that qualify for Category 1 or Category 2 credit.

If Ohio did not have an accrediting body such as OSMA, sponsors (such as hospitals and group practices) would have to seek accreditation at the national level directly through the ACCME, which would cost significantly more than the similar accreditation through OSMA. As a result, CME opportunities for physicians would likely reflect the added costs by charging higher fees to hold the CME programs, or more than likely, there would not be the variety and availability of CME in Ohio that exists today. — Yvonne Burry

CME highlights for January

Two CME programs of interest for early 1999 include:

Values in Medicine: An Ignatian Perspective

When: Jan. 15-17

Sponsor: Mercy Hospital, Canton.

Objective: To help physicians consider the values of medicine and their personal values in a spiritual and career perspective. This retreat will be held at Loyola of the Lakes in Summit County.

For more information contact: Carmela Bendetta, (330) 489-1409.

CME credits: 9

Diabetes Update for the Primary Care Physician

When: Feb. 11

Sponsor: Mt. Carmel Health System, Columbus.

Objective: To update physicians on diagnosis and management of diabetes for patients of all ages with all types of diabetes. Scheduled for 1-4:30 p.m. at Mt. Carmel Medical Center (West).

For more information contact: Cynthia Scott Kemp, (614) 234-5351.

CME credits: 2.5

For a complete updated list of CME opportunities around the state, check the OSMA Web site at www.osma.org.

OSMA Profile

A demographic look at your association.

The under-40 crowd

If you're a physician under the age of 40, or in your first five years of practice, you are officially a "Young Physician," and, according to OSMA records, the association has 1,868 such members on its rolls.



The youngest "young physicians" are 28-years old (there are four), and the largest group (some 307 physicians) squeak by in the 39-year-old class.

What specialties do young physicians practice these days? Man-

aged care's recent push to persuade more new doctors to go into primary care areas seems to be working. Here are the top 10 specialties for OSMA's Young Physicians:

1. Family practice (272)
2. Internal medicine (263)
3. Obstetrics and Gynecology (135)
4. General surgery (117)
5. Pediatrics (100)
6. Anesthesiology (90)
7. Ophthalmology (76) and Orthopedic surgery (76)
8. Cardiovascular disease (55)
9. Otolaryngology (33)
10. Diagnostic radiology (31)

Alliance report

Fall Focus highlights managed care

The Ohio State Medical Association held its Fall Focus

conference on Nov. 17-18, 1998 at the Adams Mark Hotel in Columbus. The keynote speaker was OSMA President Lance A. Talmage, MD, who talked to and with the conference attendees about issues facing medicine, and in particular, Ohio medicine.

As always, Dr. Talmage was informative, insightful and reassuring. Ohio medicine is in very good hands. Brent Mulgrew, OSMA executive director, also stopped in on the conferences. We thank them both.

The issue that riveted the audience was managed care. Jean Wankeene, AMA Alliance Field Director for Ohio, traveled from Jefferson City, Missouri to speak about managed care. She is well qualified to do that, as she is manager of Jefferson City Eye Consultants and managed-care coordinator for the Jefferson City Medical Group.

Following Sally Lewis' narrative about a day in the office of a physician under managed-care contracts, Wankeene took the audience through the history, legislation, and issues of the topic. Physicians are at a tremendous disadvantage because of the power of



Nancy Goorey, DDS

the managed-care companies.

The balance of power between the managed-care organizations (MCOs), and the physicians is a major reason why physicians must be vigilant about their contracts, why they must be involved in legislation, and why it is so critical that they stand unified to make their voice heard.

According to the AMA 1998 Conference for CPA/Medical Practice Consultants, it has been said that many agreements running between MCOs and physicians are virtual contracts of adhesion. Contracts of adhesion are characterized by gross inequality of bargaining power between the parties and the imposition of hard, sometimes unconscionable terms because of that inequality.

Is there a physician who would not agree that this is the present situation?

Asked "Why should we belong to the county, state and national medical organizations and Alliances?" this is the most compelling of arguments. The only way to be strong and have bargaining power is to band together and make an impact. The more the balance is equalized, the more fairly will physicians and their patients be treated.

The Alliances will do our part. Fall Focus provided the education for our members to be more knowledgeable. Now, we must all replace our frustration with action so that the best of the practice of medicine can thrive. ■

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Please send CV to: Gary LeRoy, MD, 2132 E. Third Street, Dayton, Ohio 45403; or fax to (937) 208-6866.

RHEUMATOLOGIST (BC/BE) - sought to join busy multi-interest practice in the Mayfield Village, Ohio area. Strong, vital and well established Rheumatology practice looking for a second Rheumatologist to help facilitate our continued expansion and growth. Our areas of interest are comprehensive rheumatic disease care, a clinical center for osteoporosis and a very active clinical research division. On site lab and DXA densitometry. We offer a unique opportunity for professional expression in patient care and clinical research.

For more information, contact: Andrea Driscoll, Practice Manager, 6551 Wilson Mills Rd., #106, Mayfield Village, Ohio 44143.

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Things are not always as innocent as they seem. What physicians and surgeons once trusted as the most basic of safety precautions has frequently turned into a life-altering threat. Victims of Type I Latex poisoning daily face dangerous exposure from such seemingly harmless sources as a child's toy balloon. This can result in devastating career and lifestyle changes — and in some instances, even death!

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On the Web...

Legislation section reorganized



If you'd like to see what the OSMA Legislative Department has done on behalf of Ohio physicians' during 1997-1998, visit our Web site at www.osma.org and go to the "Legislation" section. Once there, you'll find an Overview of the 122nd Ohio General Assembly listing the important health-care issues.

Over the past two years, some 82 different health-care proposals were considered – 18 of which were enacted. The highlights of OSMA's legislative accomplishments are listed as well as a list of potential issues for the 1999-2000 legislative session. By visiting the site you'll get a sneak preview of new health-care issues that will surface in 1999.

OSMA members can get even more legislative information by visiting the "Current Bills" section in the legislation area. This section, which is for members-only so it is password protected, allows browsers to call up any Senate or House Bill by its number. All of the bills and their titles are listed.

The OSMA is currently working to make this feature even more convenient for members. We hope in early 1999, members will have the option of searching for a particular bill by number or by category. The new feature — putting all the bills into categories — will make it easier for members to locate a bill even if they don't know the number and without scrolling through an entire list of bill numbers.

Sweepstakes winner

Thanks to all the members who participated in our contest to win a weekend package at the Hyatt Regency in Cincinnati.

Brady Stoner, MD, Cambridge, won the Friday night stay and dinner for two at Champ's Restaurant located in the Hyatt Regency.

Send your e-mail address or any suggestions about the OSMA Web site to Karen Kirk at: kkirk@osma.org. ■

OSMA happenings...

- Skin cancer education material to be sent to schools...In response to Resolution 34-98, Educating Students About the Hazards of Tanning, the OSMA, in cooperation with the Ohio Dermatological Association, has prepared materials to assist county medical societies who wish to work with local schools on skin cancer awareness. The resolution called for the OSMA to urge each county medical society to pass a resolution to work with individual school districts and other schools in their county to educate students about the hazards of tanning and how to prevent skin cancer. The materials are scheduled to be sent to county medical societies this month. If you would like a copy of the materials sent on this topic and you are an OSMA member, call the *Ohio Medicine* reader response line, (800) 766-6762, Ext. 6580, and ask for item #3-99.

- Katrina English leaves OSMA...Katrina English, director of the OSMA Division of Legal Affairs, and the association's chief legal counsel, left the association in mid-December to assume the position of legal counsel for OhioHealth. She had been with the association for eight and a half years.

- CME on the Web...The OSMA is working with the Ohio Department of Health to launch a CME course on breast cancer screening on the OSMA Web site, www.osma.org. Look for it later this year. Also this year: The association's Education Committee will renew credit for the OSMA's domestic violence material and will offer new CME opportunities through an osteoporosis initiative scheduled for this spring.

- Team physicians honored...The Joint Advisory Committee on Sports Medicine will hold its annual meeting at the Cherry Valley Lodge in Newark on Jan. 23 and 24. As part of its program, the Advisory Committee will honor the following team physicians: Thomas F. Bear, MD, Cuyahoga Falls; Raymond Giles, MD, New Philadelphia (posthumous award); Robert L. Gerber, MD, Sugarcreek; Robert P. Koenig, MD, Cincinnati; and James John Otis, MD, Celina. Watch future issues of *Ohio Medicine* for more information on these outstanding team physicians.

- New customized, on-site educational programs coming to group practice members...The OSMA Group Practice Section will try to make its educational program more pertinent to members this year by eliminating its traditional, seminar-style presentation, offered each year in Columbus, and develop, instead, a "menu" of educational options. Section members will select from this list of timely topics those programs most relevant for them – in effect "customizing" their own educational training. To make the program even more appealing, OSMA staff will arrange to take the presentations to the groups. "We'll go on the road, bringing these programs directly to the group practices that want them," says Susan Rupli, director of OSMA Group Practice Services. "We'll schedule these presentations according to the group's availability (not ours), and alleviate the physician's burden of taking time away from the practice to travel to Columbus." If your group is a member of the OSMA Group Practice Section, and you are interested in learning more about these new educational programs, contact Susan Rupli, (800) 766-6762, Ext. 6775 for more information.

Unity of physicians is absolutely necessary

Given the events of the past several months, someone might suspect that I am ambivalent regarding the importance of the county medical society. Nothing could be further from the truth. When I started in organized medicine, it was at the county level, and I found that the services and opportunities there satisfied many of my needs as a young practitioner.

The ability to join fellow physicians to advocate for good health practices in the community gave me exposure and a sense of accomplishment that complimented the maximum number of patients I could see each day. I worked with the health department, lay groups and charitable organizations to assist members of the community less fortunate than ourselves who are in need of quality health care and preventative services. The comradery of discussing medicine with other specialists and other hospitals staff's helped to acclimate me to my community.

I found that those needs still were just as great after I had been in practice for a number of years, and I also found other needs that the county medical society could not fulfill. Insurance plans that can be discounted because of the much larger numbers the state association is able to offer were a help to my family and to me. Advocacy for state laws and administrative rules made it more comfortable for me to practice, and avoided some of the hassle factors that I found in the office. The state was also the point at which I could be educated on business matters in the office, and later, on public health issues such as domestic violence, immunizations and other topics.

I then became aware of the AMA influence on the federal laws and regulations which affected my practice in many ways. Again, I found that addressing the needs at the federal level



Lance Talmage, MD

President's Perspectives

did not lessen any of the needs that were being met at the state and county levels.

Despite the impression that the younger physician feels less need of networking, and accepts more passively the inroads of state and federal government, I still do not see any diminished role for each of the important parts of organized medicine. Hopefully, the young physicians, as they encounter the hassle factors in practice, will find that their needs may be better met by joining organized medicine. Each of us who believe this should try to influence medical students, residents and younger partners. The academic arena has pushed the specialty societies because those physicians have generally found more acceptance in specialty societies, as well as more leadership roles. Yet, the need for all physicians to belong to specialty societies and organized medicine has never been greater. The unity of physicians in the face of government intervention (state more than federal at present) is absolutely necessary.

The connection in the bylaws of the state and counties that exists in Ohio has been reaffirmed on frequent occasions in the last several years. To break out of that tradition is, so far, unacceptable to the majority of our members. Unity and mutual support is achieved through debate, compromise and consensus. Without that process, we will be cut into small groups which can be dispatched, one by one, by groups more unified in their vision and profit motivation. We must be cohesive or accept the inevitable loss of quality patient-oriented medicine. ■

Practice Tips



Your own Web site: Is it effective, ethical?

If you have decided your practice needs a presence on the Web, and you have created your own Web site, either by yourself or with the help of a designer (see last month's issue of *Ohio Medicine* for more information on both of these subjects), your next step will be to measure your site's effectiveness.

Effectiveness can be measured by tracking site use through weekly reports generated by your server. Most servers will be able to provide you with records of the:

- Number of times your site was visited.
- Number of visitors to your site.
- Number of single pages visitors "hit" while on your site.

Hits vs. visits

It's important to remember the difference between "visit" and "hit" in determining the effectiveness of your site. Each time someone visits your site, and clicks on a page at that site, that measurement will be listed as a "hit" – therefore, you can expect "hits" to be higher than the number of visitors when you receive your measurement report. In November, for example, the OSMA's Web site received 2,505 "hits" by 178 visitors.

If you notice that a number of visitors are entering your site, then leaving without seeing any other pages, it may be an indication that your home page, the first page your visitor sees, needs to be more compelling.

Tweaking your site

Your server can provide you with other measurements that are also helpful in measuring your site's effectiveness. For example:

- The most common visitors to your

site (by address).

- Other Web sites that have brought visitors to your site through links.
- Your site's most popular pages.
- On which pages your visitors enter and leave the site.
- The most popular days and times your visitors come to your site.

All of this information can be used to tweak your site and make it more effective. The OSMA learned

that most of its visitors come to its Web site on Mondays and Wednesdays; so updates are always posted on Tuesdays and Fridays. You can make similar adjustments. If you discover the heaviest use of your site is around noon, for instance, you'll want to make certain your updates are made in the morning. And you'll soon discover which pages you'll want to trim – or expand – according to your visitors' use.

In addition to the weekly reports generated by your server, you may also test your site's effectiveness by having your office staff asking and noting where new patients found your name and phone number. (Tip: Be sure your Web site address is listed on everything you print.)

Are Web sites ethical?

Are there ethical and legal issues unique to the Internet? According to OSMA member Victoria Ruff, MD, Columbus, who serves on the AMA Council on Ethical and Judicial Affairs, the opinions and standards that are now in place for physician advertising appear to be sufficient in gov-



The effectiveness of your own Web site can be measured by tracking site use through weekly reports generated by your server.

erning Web sites.

Don't however try to diagnose and prescribe on the Web. Recently, investigations were launched into the practices of several physicians (not Ohioans) who prescribed Viagra and fen-phen over the Internet without taking full medical histories of the patients. The AMA says "telemedicine" with existing patients is acceptable, but prescribing by phone, without seeing the patient, is not. Same goes for prescribing by Internet.

The Internet structure presents some new legal challenges as well – such as patient confidentiality. Several levels of security can be built into your computer, Web site, and e-mail systems. Check with your Web site designer on how to secure your site.

The bottom line is this: The healthcare marketplace is a brave, new world of ever-emerging technologies and rapid-pace communications. If your practice is to keep pace in the race for patients, then a Web site may belong in your marketing strategy – *Carol Larimer*

BWC makes changes in 1999 provider fee schedule

The Bureau of Workers' Compensation (BWC) conducted a review of its 1998 provider reimbursement fee schedule for its Health Partnership Program (HPP).

The schedule is actually several years old, and was developed with input from the OSMA.

According to a recent BWC memo, "This review revealed that implementation of a single conversion factor to the Health Care Finance Administration's (HCFA) relative value units and geographic practice cost indices will result in significant changes to some portions of the fee schedule."

In order to maintain current levels of provider participation in the HPP, the BWC will retain, for the most part, the 1998 reimbursement levels, and will continue to look at alternative methods for determining adequate, equitable provider reimbursement.

The 1999 Provider Fee Schedule, including newly created 1999 CPT codes, will appear in the *1999 Provider Billing and Reimbursement Manual*, which will be released this month. You will also receive at that time, the 1999 Provider Fee Schedule Addendum, which will include the new '99 CPT codes and fees, as well as changes to the HCPCS Level II and III codes. The addendum should be used in conjunction with BWC's 1998 Provider Fee Schedule.

The BWC will not publish a new 1999 Provider Fee Schedule – however, you may download a version from the BWC's Web site. (Visit OSMA's Web site, www.osma.org and link from there.)

The changes to the HPP Provider Schedule were recommended by external consultants to the BWC. The OSMA was not asked for input. ■

Medicare discontinues its toll-free claims submission lines

Once again, providers outside of the central Ohio area will have to pay a toll charge for electronic submissions of their claims. There are options you can pursue to reduce the costs, however.

All affected medical practices have been informed, the Health Care Financing Administration (HCFA) will no longer fund carriers for toll-free lines for electronic claims transmission, effective Jan. 1.

"This policy is unfair to physicians not located in central Ohio," says Bill Fry, OSMA Ombudsman director. "We've heard from several members about this, and have discussed it with Medicare staff."

Physicians respond to action

As Steven G. Roshon, MD, FACP, observed, "Medicare set up a variety of incentives to participate in the Medicare program. This included certain services not available to those not participating. One of these was a toll-free line for claims submission. Soon, there will again be a toll charge. It occurs to me that removal of these benefits amounts to a breach of contract. In addition, this policy discriminates against providers not living in the 614

telephone exchange area."

David L. Welsky, MD, PhD, noted, "This is another episode of Medicare cost-of-services being taken out of the equation, and being placed on the doctors. Patients receive tremendously higher value during office visits than they did in the 1960s, partly because of physicians' investments in newly-available technology. I'm a sole practitioner, and to support me, we have a nurse plus four other people, and a computer in every room. The return to the physician since the 1960s has not kept pace with inflation. We receive back, on average, only 60% of the charge for office visits from commercial carriers and even less from Medicare."

"Physicians were very accommodating to embrace the electronic claims system, as quicker and more efficient. Electronic claims filing makes up about 70-80%. Now, Medicare is withdrawing part of the incentive, and the cost reverts to the doctors — misleading to say the least," says Fry.

Several options still available

Fry said that the toll-free line discontinuation evidently is not negotiable, and will, in fact, occur as scheduled. However, Medicare EDI Division of Nationwide Mutual Insurance Co.

New code edits may mean denied claims

Physicians should closely monitor any Medicare claims denials made after Oct. 1, 1998, and appeal any questionable denials, says the American Medical Association (AMA).

That's because, on Oct. 1, Medicare carriers began to use approximately 200 new code edits, due, in part, to Congress pressuring the Health Care Financing Administration last May to implement stricter claims editing to assure appropriate use of Medicare funds. The new code edits are not part

of the "Correct Coding Initiative" already in place, however, and none will be made available to the public — a point that raises strong opposition from the AMA.

You will likely receive claims denials with standardized language explaining the denial, but no explanation of the edit itself will be provided.

If you have questions or comments concerning the denials, you should address them to Nationwide-Medicare. ■

does have several suggestions for reducing submission costs.

1. Use compression during asynchronous file transfers. Three compression software packages that are compatible with the Medicare system and highly supported will tremendously reduce online time while sending and receiving files. These are: UNIX Compress; PKZIP (versions 2.04g and higher); and GZIP.

According to Brian Bruckelmeyer, OSMA Electronic Data Services, the second two can be downloaded, free, through <http://download.com>. After reaching the site, go to Utilities, then to File Compression, then choose the software you desire.

2. Increase your modem speed, if possible. The highest modem speed currently available for Medicare claims submission is 28.8.

3. Submit during non-peak hours

for lowest telephone rates. The claims system is available online 24 hours a day.

4. Shop for the lowest long-distance telephone rates. Packages change, and you may not be receiving the best available rates for your needs.

5. File claims daily, rather than monthly. The interest you earn on this early-money can offset your long-distance phone costs.

Medicare carriers cannot accept electronic claims via the Internet, as this would risk the privacy of Medicare beneficiary data. However, HCFA is exploring the Internet option. *Ohio Medicine* will keep you posted as this becomes a future option. — Carol Larimer

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Managed-care roundup

Anthem expands information service...Anthem Blue Cross/Blue Shield has expanded its health information service, Personal Health Advisor, to Anthem members in Akron, Canton, Cleveland, Warren and Youngstown. Personal Health Advisor offers round-the-clock health information to Anthem enrollees through a toll-free telephone number (888) 474-2258 and a Web site www.pha-online.com/anthem.

MedPartners sells off its group practices...The nation's largest manager of group medical practices, MedPartners, plans to sell all of its 238 physician offices nationwide, citing reduced payments from insurers and inadequate amount of patients as the reason.

QualChoice pulls Medicare HMOs out of Lake County...University Hospitals Health System's QualChoice Health Plan is pulling its Medicare product from Lake County on Jan. 1. About 1,500 enrollees are affected. Insufficient government reimbursement is given as the reason for the withdrawal. Enrollees will have to enroll in another Medicare HMO, or return to traditional Medicare.

Central Ohio sees new managed-care system...A popular West Coast managed-care company that's designed to negotiate managed-care contracts for its physicians is bowing into the Central Ohio market through American Health Network of Westerville, a group of 65 primary care physicians. The company, Telesis, negotiates global risk contracts with HMOs for the group it contracts with. Telesis already operates in Youngstown, Cleveland and Cincinnati. Daniel Gregorie, MD, former chief of Cincinnati's ChoiceCare, is CEO for Ohio operations.

Unless you're a certified provider, BWC won't pay

If you have not been certified, yet, as a provider under the Ohio Bureau of Workers' Compensation (BWC) Health Partnership Program, you may no longer be reimbursed for treatment to injured workers.

Beginning Jan. 1, providers must be BWC-certified to be reimbursed for treatment, except for:

- state fund claims with dates of injury prior to Oct. 20, 1993
- emergencies
- initial visits

For claims with injury dates before Oct. 20, 1993, the patient may continue treatment with a noncertified provider, but a managed-care organization (MCO) will manage the care. If the worker should change providers during the course of treatment, he or she will have to select a certified provider to continue.

You should be aware that providers must be certified to participate on a MCO panel — and just because you

now belong to a MCO panel does not mean you are certified.

Last month, the BWC notified the injured workers of noncertified providers about the providers' noncertified status. If you become certified (see "Take Action" below), you may wish to contact your injured worker patients to make them aware of the change in your status. ■

Take Action

Completion of the BWC certification process will allow providers to continue to treat injured workers and be reimbursed for their services. To receive information on how to continue treating Ohio's injured workers and remain active in the BWC provider files, providers may call the HPP Inquiry Team at (800) 644-6292, and press 42. In many cases, providers will only need to sign the Provider Agreement to complete the certification process.



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FRIDAY - April 23, 1999

Pittsburgh, PA:

FRIDAY - May 7, 1999

Call 1-800-951-7007 for more information. Or, check out our web site at www.seidenadventure.com

Decision delayed on Item #32

Medicare has decided to postpone the decision it made at the end of 1998 regarding Item #32 on the HCFA-1500 claim form. Item #32 replaces codes #21, 22, and 23. According to the Health Care Financing Administration (HCFA), if a physician performed a service in a hospital, he or she must enter the facility's Medicare provider number, in addition to the facility's name and address.

Medicare will announce in its January newsletter that HCFA has delayed implementing the requirement for now, and there has been no word, yet, as to when a final decision will be made. *Ohio Medicine* will provide you with an update as soon as word becomes available.

If you have questions about this or other Medicare matters, contact Jennifer Hyle (Ext. 6757) in the OSMA Ombudsman office, (800) 766-6762. ■



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AMA seeks examples of Medicare audit problems

Disturbed by intense scrutiny by the Health Care Financing Administration (HCFA), the AMA is asking physicians for reports of difficulties with Medicare prepayment reviews and screens and postpayment audits. Executive Vice President E. Ratcliffe Anderson Jr., MD, explained the AMA's concerns in a recent letter to HCFA Administrator Nancy-Ann DePare. Among them:

- Prepayment reviews. The AMA questions the value of prepayment re-

views of Evaluation and Management (E&M) services and suggests that HCFA focus on documented outliers. Although HCFA claims interest in substantive disputes only, carriers are homing in on coding differences as small as one level. In addition, the AMA has heard reports of carrier error, including lack of familiarity with the 1997 E&M guidelines.

- Postpayment audits. Physicians have only 30 days from the date of the letter to respond to notification of an overpayment. Since mail delivery can be unpredictable, a physician may be left with little time to decide how to respond. The AMA would like a 60-day response period. The AMA is also concerned about the lack of feedback to physicians on how to correct billing problems, the lack of carrier expertise, the limited options for physicians who have overbilled and the extrapolation method HCFA uses to determine the amount of overpayment.

- Prepayment screens. Carriers often conduct prepayment screens for codes for which a physician has been overpaid. There is no time limit on such reviews, and the impact on cash flow could force some physicians out of business.

- Critical care medicine. Although critical care policies are still being crafted, some carriers are using local medical review policies (LMRPs) more restrictive than HCFA's. The AMA urges that critical care audits be suspended until HCFA clarifies its policies and billing requirements.

Legitimate physician errors are being treated as fraud, says James H. Stacey, director of the AMA's Washington Media Relations Office. "What we're looking for is better guidance on compliance with the rules. And we feel that, without question, almost every physician in the country wants to do the right thing for his or her patients and bill in the correct fashion. We do not think the system is riddled with fraud."

"I think that the profession is proba-

bly feeling put upon to be considered guilty before they get a chance to find out what the problem is," adds Bill Fry, director of the OSMA Department of Ombudsman Services. "In one particular instance, the FBI has come to a doctor's office."

Ombudsman Services is available to help physicians understand the audit process. OSMA also has a certified coder on staff.

If a determination of overpayment is made, Ombudsman Services will advise the physician on whether to pay it back or appeal. "Sometimes it's so blatantly obvious that the physician created the error in billing that the best advice is to not pay interest," Fry says. "Just go ahead and pay them. But a lot of times I'm finding that the Medicare policy may not be clear and the carrier is holding the doctor responsible." —
Jan Leibovitz Alloy

Take Action

For more information on Medicare audits, contact: Bill Fry, director, OSMA Department of Ombudsman Services, (800) 766-6762, Ext. 6760 or Jillian Phillips, OSMA certified coder, (800) 766-6762, Ext. 6758. If you are having problems with prepayment reviews or screens or postpayment audits, contact Margaret Garikes in the AMA's Washington office, (202) 789-7409.

Medicare audits may not be correct

Medicare carriers may not be using both the old and new guidelines when they perform pre-and-post-payment audits – despite an article in the Ohio Medicare newsletter that stated: "As required by HCFA, (Nationwide-Medicare) reviewers use both the old and new guidelines in determining the level actually documented."

According to Jillian Phillips, MA, CCS-P, CPC, Certified Coding Consultant in the OSMA Department of Ombudsman Services, the OSMA is becoming more involved in helping physicians reduce the amounts that Medicare says they owe because the audits were based on new guidelines only. If you are audited, Phillips advises you to audit your own records, based on both the old and new guidelines.

Take Action

Copies of the guidelines (old and new), as well as coding assistance are available through the OSMA Department of Ombudsman Services, (800) 766-6762.

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Colleagues

Newsmakers

HERMAN I. ABROMOWITZ, MD, Dayton, has become a member of the Commission on Office Laboratory Accreditation (COLA) board of directors. COLA is a na-

tional health-care accreditation organization. Dr. Abromowitz, a representative from the American Medical Association (AMA), was officially ap-



Herman I.
Abromowitz, MD

pointed to the board at COLA's recent meeting held in Baltimore.

CARL P. HERKIMER, MD, Toledo, was honored with the prestigious Clair F. Martig Award during St. Luke's Hospital's Annual Pacesetters Club Recognition Dinner held Oct. 8. The Martig Award is given annually to an individual who has substantially contributed to the growth and prosperity of St. Luke's Hospital.

DAVID W. HUNTER, MD, Toledo, is the midwest governor of the regional, state and local Allergy, Asthma and Immunology Society. He is also immediate past president of the Ohio Allergy, Asthma and Immunology Society.

ROGER J. KRUSE, MD, Toledo, served as the director for Team USA Camp held at the Olympic Training Center in Colorado Springs, Colorado. Dr. Kruse is the director of Sports Science and Sports Science Camps for the United States Figure Skating Association.

AARON PERLMAN, MD, Cincinnati, is the 14th recipient of the Medical Foundation's Daniel Drake Humanitarian Award. This award is given to a living physician who displays a history of selfless dedication to the needs of others and has made humanitarian contributions to medicine and the community. Dr. Perlman, an orthopedic surgeon, served as director of pediatric orthopedics and was co-director of Children's Cerebral Palsy Clinic at Children's Hospital Medical Center.

DONALD SENHAUSER, MD, Columbus, received the Frank W. Hartman Memorial Award at the American Society of Clinical Pathologists' College of American Pathologists' fall meeting for his more

Obituaries

LEORY B. BLOOMBERG, MD, Newark, Ohio State University College of Medicine, Columbus, OH, 1964; age 59; died Oct. 16, 1998.

ROY L. KILE, MD, FL, University of Cincinnati, College of Medicine, Cincinnati, OH, 1933; age 89; died Oct. 21, 1998.

KHAWAR M. SYED, MD, Cleveland, King Edward Medical College, Lahore, West Pakistan, 1970; age 51; died Nov. 10, 1998.

than 25 years of service to the organization.

JAMES S. TAYLOR, MD, Cleveland, received the Ohio Dermatologist of the Year (1998) Award, presented by President Louis L. Barich, MD, at the Ohio Dermatological Association's Annual Meeting Sept. 18-20. This award is given to a physician who displays a history of exemplary commitment, outstanding efforts and distinguished leadership.



James S. Taylor, MD

Send us your colleagues

If you know of an OSMA member who has recently received an award, or been recognized for outstanding achievement, please send that information along with a photo of the physician to:

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February 1999

Ohio Medicine

A Publication of the Ohio State Medical Association

OSMA and OHA sue state agencies over failed HMO

3
If you have been sued three times for malpractice in suits involving \$25,000 or more within five years, the State Medical Board of Ohio is now required to launch an investigation.

8

Professional courtesy now involves risks, and if your practice has a long-standing policy of extending such courtesies to other professionals, families or staff members, you may be wise to review those risks.

11

March 15 is the deadline for OSMA resolutions. If you want organized medicine to address your concerns, you need to first submit a resolution. Here's how that is done.

B

Confused by the medical board's staggered license renewal system? A booklet produced by the Medical Board and a new recordkeeping folder, included in this issue, should help.

Go shopping

The OSMA offers a variety of practice aids as well as patient information to Ohio physicians through its "virtual" store. Visit the OSMA Web site at www.osma.org.

On Jan. 12, 1999, OSMA and the OHA: Association of Hospitals and Health Systems, filed suit against the state for millions of dollars over problems stemming from a failed HMO. Two state agencies are named in the suit: the Ohio Department of Insurance (ODI) and the Ohio Department of Human Services (ODHS).

The OSMA and OHA are charging that these agencies failed in their duties to oversee the financial stability of Personal Physician Care, Inc. (PPC), a Medicaid HMO located in northeast Ohio. At one point, PPC was the largest Medicaid HMO in Cuyahoga County, with 35,000 enrollees in that county alone. PPC, when placed in liquidation in August, owed hospitals and physicians more than \$15 million for services rendered to Medicaid patients in 1997 and 1998. As part of the liquidation process, some physicians and hospitals are being asked to return some of the money they were paid. The class action suit was filed in the Ohio Court of Claims.

Besides the immediate concern over the physicians and hospitals who are owed money by PPC, the OSMA and the OHA are concerned that other state Medicaid HMOs may be experiencing similar financial problems that have not been detected by ODI and ODHS. In an article in the Cleveland *Plain Dealer*, Alan Freund, a Medicaid policy coordinator in HCFA's Chicago office also expressed concern. Freund said the program that HCFA approved in Ohio requires the two agencies to coordinate the oversight of HMOs to ensure their financial stability. "We're concerned that the situation occurred and it got to this point that we have these providers that have apparently lost money," Freund said. "We would like to see how

the state intends to improve the monitoring so that it will not occur in the future. We know it's a very volatile market in Ohio. We don't want beneficiaries or providers to suffer losses."

The OSMA will provide updates on this issue on its Web site and in *Ohio Medicine and Leadership Briefing*. ■

Take Action

To obtain a copy of the OSMA joint news release call the Ohio Medicine

reader response line, (800) 766-6762, Ext. 6580, and ask for Item #4-99. Any member who had a PPC contract or provided services to a PPC-covered patient starting in 1997, and who still has outstanding claims may be eligible to participate in the class action suit. Please notify the OSMA, in writing, of your situation. Send notice to: OSMA, 3401 Mill Run Drive, Hilliard, OH, 43026, ATTN: Medicaid Lawsuit.

Fraud and abuse data bank proposed

The National Practitioner Data Bank may not be the only database to keep statistics on what it considers errant physicians. The Office of the Inspector General (OIG) has proposed the "Health Care Fraud and Abuse Data Collection Program" as a new preventive measure in its effort to combat health care fraud and abuse.

The proposed fraud and abuse data bank would receive certain final adverse actions against health-care providers, suppliers or practitioners and make that information available to: Federal and state government agencies (including Medicare carriers which contract with the government); health plans; and any health-care practitioner, supplier or provider who requests information about himself, herself, or itself.

The proposed rule was published in the *Federal Register* in October, and the comment period was extended through Jan. 11, 1999. The AMA submitted a lengthy response to the OIG outlining numerous concerns. ■



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Bills, Laws & Rules

Legislative update

Legislators to tackle new, old issues as session begins

As health-care professionals know, there are some significant issues in front of state legislators this session. But we'll have some competition in 1999 as lawmakers juggle medicine's priorities with the likes of education funding, writing and approving the latest version of their two-year operating budget, and electric utility deregulation.

During the 122nd General Assembly 1998, the OSMA legislative team monitored nearly 100 issues related to health care. Among these, nearly a dozen managed-care bills were considered in the Ohio House of Representatives and eight measures in the Senate. Tim Maglione, OSMA director of legislation, says, "Because so much unfinished work remains, we'll see the reintroduction of many bills, picking up where last year's legislative agenda left off."

Many issues for 1999 may spark confrontational debate. Maglione says, "Watch for highly emotional discussions, both pro and con, among both organized medicine and business groups, special interest groups, health-insurers and allied practitioners, as each jockeys to support its own priorities."

"Common sense is on our side...it should help," says Maglione.

In the new General Assembly, the OSMA legislative team will devote its energies to keeping legislators on track related to such issues as physician license fees, Medicaid reimbursement, finance of long-term care, and expanding the children's health-care initiative (CHIP). Although only a few new top-

ics related to health care are expected to emerge from the upcoming session, Maglione expects a very busy year. Here's why:

PHPA

The Physician-Health Plan Partnership Act (PHPA), the cornerstone of the OSMA's 1998 legislative agenda (House Bill 361), became law on Oct. 1, 1998. This benchmark piece of legislation sets minimum operating standards for quality, affordability and access among managed-care plans in Ohio. The bill, developed by OSMA and Kaiser-Permanente, establishes patient protections like defined grievance procedures for adverse utilization review and access to nonformulary prescriptions.

Ohio Gov. Bob Taft wants to complement the protection in HB 361 by expanding an external appeal right to cover "life-threatening conditions." Gov. Taft also wants to see HMO directors licensed by the State Medical Board so that their decisions will be under the board's oversight. The OSMA will keep you updated on related pieces of legislation as they move through the General Assembly.

Managed-care accountability

Should managed-care organizations substitute their judgment over treating physicians for what is medically appropriate for a patient? This controversial, emotional bill will certainly be in the spotlight in 1999. If such action is allowed, then is the managed-care plan accountable for mistakes or harm caused by its decisions? The OSMA supports the idea that plans should

accept liability when they take charge of decision-making.

Additional patient access

Will the Legislature expand health care for uninsured families with incomes slightly above the poverty level? A legislative task force has recommended well-child checkups and immunization, preserving private sector insurance for those who have access, and monitoring the quality of children's care through the CHIP II program. Other access scenarios also may be discussed.

Advanced Practice Nurses (APNs)

This hotly debated issue concerns APNs who desire prescriptive privileges. While this issue may blur the line between the practice of medicine and the practice of nursing, the larger concern is how such a system, if enacted, could be properly supervised to assure patient safety. The OSMA will oppose any legislative effort to expand prescriptive authority for allied practitioners.

Prompt pay

OSMA member physicians are very interested in seeing this issue resolved. Managed-care organizations have openly ignored the 24-day prompt payment law and tend to hold on to payments for months before reimbursing health-care providers. Less than rigorous enforcement by the Ohio Department of Insurance simply exacerbates the problem. The OSMA aims to put

Repeated malpractice suits to be investigated

Signed into law on Dec. 11, 1998, the Medical Board Bill contains several provisions that impact physicians in Ohio.

Thomas A. Dilling, government affairs officer for the State Medical Board of Ohio says, "A clause in HB 606 changes wording so that we are mandated to investigate repeated malpractice suits where before, the clause said we may (choose to) investigate such cases." Repeated malpractice is now defined as three suits of \$25,000 or more during five years. "The medical board would have authority to investigate...a violation of the Medical Practice Act," says Dilling. "But that does not necessarily mean there will be disciplinary action," he adds. "All investigations are confidential."

Clarifications in the law also affect disciplinary action. In one provision, new wording aligns legal authority and nomenclature with the "reasonable care" designation. This clause delineates minimal standards of care for all patients. Another part of the bill clarified a hospital's duty to report disciplinary action, says Dilling.

Unlicensed practice of medicine is now a felony. Additionally, "If a physician is ordered by the board to take a physical or mental exam related to their ability to practice medicine," says Dilling, "the physician now must pay for that examination."

A further provision relates to training certificates for interns, residents and clinical fellows. Such certificates had been optional previously. The new regulations ensure that every practitioner in Ohio has some sort of licensure and the Medical Board has some jurisdiction over them.

One final highlight is that the board can now permanently revoke a physician's license. —

Yvonne H. Burry

continued on page 6

Postgraduate training for PAs may be latest issue in expanding scopes of practice

The State Medical Board of Ohio's Physician Assistant (PA) Committee is studying the issue of postgraduate training programs for PAs, and whether or not PAs in such programs can practice without registration or without a standard utilization plan.

The committee has indicated that, although the board supports postgraduate training, PAs need registration to work and must work under an approved utilization plan.

Meanwhile, some board members question whether or not PA residency programs are statutorily permissible, although there is nothing in Ohio statutes, at present, that addresses the subject of PA postgraduate training.

Other concerns raised by board members included:

- Are the PAs involved in residency training programs there for educational purposes, or to do the work that's needed?

- Will material be taken from resident training programs?

- Will a residency program allow PAs to legitimately expand their scope of practice?

- Will medical students, who already have to compete with nursing students, now have another layer of competition for training?

- What effect would a PA residency program have on the money available for graduate medical education?

The board plans to review the subject again in the future.

Giving away their livelihood

Before leaving the subject of physician assistants, the board denied a supplemental plan, submitted by a medical group, that would allow a PA to perform lumbar puncture. The PA Committee disallowed the service as outside the scope of practice and education of a PA.

One board member commented that, when he sees these types of plans

Medical Board Report

submitted by physicians, he believes physicians can only blame themselves when it comes to the erosion of their profession. As another board member put it, the profession is giving away its own livelihood. "They are losing money, and after a while, they'll be losing jobs," said a third board member.

Of note...

Piercing complications addressed... The board's minimal standards of care committee has received complaints from physicians who are treating patients with body piercing that has resulted in complications. The physicians were asked to write a letter detailing the cases.

Policy paper to come on outpatient surgery... With nearly 70% of all operations now being performed on an outpatient basis, the Scope of Practice Committee will prepare a position paper on outpatient surgery that could be used for office-based surgery, as well as that performed in ambulatory surgical centers.

Medical decision-makers need licenses... The board's managed-care committee continues to work on developing legislation that would require an Ohio license for medical directors of managed-care organizations who make decisions affecting Ohio patients. The committee's concern is with medical directors in other states who are making decisions on Ohio patients without an Ohio license. A second issue is that those who make medical decisions will be medical doctors. ■

Update on optometrists' expanded formulary

The Optometry Board voted to add Allegra, Augmentin, Claritin, Zithromax, and Zyrtec to their formulary, but did not expand optometrists' prescriptive authority to include the antiviral drugs Famvir, Valtrex, Zovirax or the pain reliever Ultram.

As reported in the January issue of *Ohio Medicine*, the Optometry Board had wanted all of the above-named oral agents added to their drug arsenal. The Ohio Ophthalmological Society (OOS) played a significant role in keeping the four controversial drugs off the formulary.

"We submitted written comments to the Optometry Board, and spoke with the medical board about our concerns in adding those four drugs (the antivirals and pain reliever) to optometrists' formulary," says Todd Baker, executive director of the OOS. "We felt that the addition of those drugs would not be within the bounds of legislators' intent when they allowed optometrists prescription authority."

The Medical Board echoed the OOS comments at an informal meeting with the Pharmacy Board and the Optometry Board. The Optometry Board decided, finally, not to include the controversial drugs in its request for an expanded formulary.

The drafted change now proceeds through traditional rule-making channels.

"Optometrists will not be able to prescribe these drugs until the rule process is completed later this year," says Baker.

The five approved drugs are updated replacements for drugs that are already in the optometry drug formulary. ■

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Legislative update

Continued from page 3

some teeth back into the law and make it meaningful. One strategy includes building a coalition among other health-care providers who also get managed-care reimbursements, namely podiatrists and chiropractors. More voices, more clout.

Point-of-Service (POS)

Fortunately, Gov. Taft and many legislators support requiring POS options within health plans. Such support should bode well for maintaining established patient-physician relationships. The likely legislation will require insurers to market an open access plan with a requirement that the insurance product's price is actuarially established. Studies show point-of-service plans cost only about 2% to 5% more than a closed panel HMO. The pivotal factor here is choice. The OSMA will be actively involved in this debate in early 1999.

Trauma

Legislation the OSMA expects to see reintroduced in 1999 includes the statewide trauma legislation. This bill proposes to establish protocols for the triage of trauma victims, and requires these patients be taken to a hospital verified as a trauma center at a level commensurate with the victim's medical condition. The OSMA supports the general concept, however, there are concerns regarding the legislation as it was introduced. Legislative staff members have been working with the sponsor to work out the differences.

Tobacco settlement

Ohio expects up to \$10 billion over the next 25 years due to the successful settlement of a tobacco lawsuit. The OSMA's mission is to make sure that the funds get used in appropriate public health programs, such as cessation, youth education, and access to tobacco legislation.

What New Issues for 1999?

With a small anticipated venue of new bills, Maglione says, "We might see an alternative medicine and therapies bill, which would address both the efficacy and role of such practices within the traditional healing technologies." Another possible bill would involve medical record privacy issues and depending on the outcome of the Supreme Court decision on tort reform (House Bill 350), the OSMA may see another round of tort-reform legislation.

Important to the debate process, says Maglione, is that all of organized medicine work together to maximize their input on the cluster of issues as an example. The OSMA is aligning with the Ohio Academy of Family Practice (OAFP), the Ohio chapter of the American Academy of Pediatrics, and the Ohio Osteopathic Association to provide a unified voice to legislators regarding Medicaid reimbursement for primary care and developing a strategy for the advanced practice nurse legislation.

Watch for frequent legislative updates in *Ohio Medicine* as OSMA works closely with the law-making process. — Yvonne H. Burry

Rules update

Consult agreements

The State Board of Pharmacy is finalizing rules that establish standards and procedures for consult agreements between pharmacists and physicians.

A recent revamping of Ohio's pharmacy laws allows a pharmacist to manage a patient's drug therapy to the extent specified in a consult agreement with the patient's physician. A separate consult agreement must be written for each patient and for each diagnosis for which that patient receives drug therapy. The pharmacist may not dispense a drug, other than a generic equivalent, that has not been prescribed by the physician. The consult agreement must be signed by the physician, pharmacist, and patient or authorized agent of the patient and must be entered into the patient's medical record. The law requires the pharmacist to make "reasonable attempts" to contact the physician before making changes in the patient's medication and to record each action he or she takes in managing the patient's drug therapy.

Only one physician and one pharmacist may sign the consult agreement. If either is in a group that may care for the patient, the primary physician and primary pharmacist must sign the consult agreement and, according to the pharmacy rules, an alternate pharmacist must be designated in the consult agreement. The rules also will give pharmacists guidelines on a "reasonable attempt" to reach a physician.

Standards and procedures for physicians are pending.

DNR protocol options

The 25-member Do-Not-Resuscitate (DNR) Advisory Committee has sent the Ohio Department of Health (ODH) its recommendations for rules that reflect the intention of HB 354, which provides procedures to follow when withholding medical care. The proposal would offer terminally ill patients, in consultation with their physicians, two protocol options.

A patient could opt for "maximal care": administration of chest compressions, respiratory assistance, or resuscitative drugs, insertion of an artificial airway, use of a defibrillation device, and administration of a cardiac monitoring or resuscitative IV.

Or the patient could opt for "comfort care": first aid other than that for cardiopulmonary resuscitation, application of suction to the airway, administration of oxygen, positioning for comfort, bleeding control, pain medication, and emotional support.

Patients, at their option and expense, could wear wristbands to notify medical care workers of their DNR preference.

The ODH is expected to accept the proposed rules.

Once the rules have been accepted, the OSMA will produce educational material for physicians that will explain the new rules and how the law will affect them. — Jan Leibovitz Ally



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Acquainting legislators with issues, answers

A group of newly elected members to the Ohio General Assembly took time from their other orientation activities in December to participate in a health issues seminar hosted by the OSMA. The informal seminar, held at the Athletic Club of Columbus, gave the group a chance to meet the OSMA's lobbyists, hear firsthand from practicing physicians about legislative concerns, and discuss their objectives and concerns.

Tim Maglione, the OSMA director of legislation, said, "Term limits will greatly change the composition of the Ohio General Assembly by the year 2000. There will be new faces, many of whom will not be very well acquainted with health-care issues. The OSMA wants to be a primary source of help and information for legislators when health-care issues are presented to committees and the legislative floor."

While each legislator in the OSMA briefing had a different level of knowledge and interest in health-care issues, all were eager to hear about organized medicine and the potential impact of recent legislative trends on both physicians and patients – important sectors of their constituencies.

The OSMA representatives introduced themselves and briefly summarized the Physician-Health Plan Part-

nership Act (PHPA) passed in the 121st General Assembly, managed-care issues, gag rules for physicians, patient advocacy, the impact of violence on the health-care system, formulary rules, the quality of medical care, the tobacco settlement fund, point-of-service rules and other issues.

Dwight A. Scarborough, MD, and Anne Taylor, MD, represented practicing physicians. Dr. Scarborough talked about his practice in dermatology, particularly skin cancer, and his concerns over Medicare, gatekeepers in medical plan administration, and physician choice. Dr. Taylor, a plastic surgeon, briefed the group regarding solo practice and her immediate interests – prompt pay, tort reform and defining and potentially broadening the scope of practice to allied providers.

Veteran legislator, Ray Miller from the 22nd House District (D-Columbus, central/southeast area), one of the participants, voiced his interest in managed care. "Having served on the Health Committee, I know that managed care is a key piece of legislation," he says. During the coming term, he wants to focus on ways to provide the highest possible quality of health care for his urban constituents.

Among the freshman representatives, Stephen P. Buehrer from the 82nd House District (R-Delta) told the group that his district includes three



An informal seminar...OSMA member Anne Taylor, MD, (left) discusses one of medicine's concerns at a recent health-issues seminar for legislators, hosted by the OSMA. Considering her points are (left to right) Dwight Scarborough, MD; and legislators, Rep. Stephen P. Buehrer (R-Delta); and Rep. Ray Miller (D-Columbus).

counties.

"For my district, managed care is not such a big issue because people are more self-reliant...they take care of each other." Instead, he would likely focus more energies on access to good medical care and the importance of helping communities attract and retain

a practicing physician in their midst.

Attending legislators were encouraged to contact the OSMA any time they want information, clarification of pending legislation, or if they would like to contact physicians firsthand, to discuss matters related to the practice of medicine. – Yvonne H. Bury

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holzer@zoomnet.net



Program offers legislators a chance to shadow physicians

For legislators who want a quick jump-start to understanding medical practice issues, several county medical societies offer regular mini-internship programs. The Columbus Medical Association announces that on either of two upcoming dates, March 23 and June 22, participants may schedule a half day with two physicians, one primary care and one specialist. Interns, in this case, legislators, would be assigned to shadow physicians whose daily practice reflects such issues as poli-

ties, education, patient advocacy, insurance, media and even the role of the clergy. Anyone whose profession would benefit from a better understanding of medical practice and the physician-patient relationship is invited to apply to the internship program.

For further information, contact Diane McDaniel, Columbus Medical Association, 431 East Broad Street, Suite 300, Columbus, OH 43215 or phone the CMA at (614) 240-7410. – Yvonne H. Bury

Professional courtesy may be viewed as fraud



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Although Ohio law permits professional courtesy among physicians, if you waive fees for which you bill an insurance company, you could be liable for insurance fraud, says Nancy Brigner, senior associate in the health law department of Schottenstein, Zox & Dunn in Columbus. "Let's say the service was \$100," Brigner says, "and you are going to waive the copay, which is \$20. You would be submitting a bill as if you were charging \$100 for that service, when in fact you're only charging \$80. So in that sense you're submitting a false bill."

"It could also be a problem if you waive it only for physicians who are good referral sources for you," Brigner says. "You're going to get into some antikickback issues if you're trying to do it to induce referrals from those other physicians."

Yet another problem is waiving fees for family members or office staff. State law allows physician-to-physician courtesy only.

Federal law has no specific provision regarding professional courtesy, Brigner says. The provisions of the Health Insurance Portability and Accountability Act (HIPPA), however, discourage the practice.

As you develop a compliance plan for your practice, it's important to include in your review of office practices an assessment of when and for whom you waive fees. If extending professional courtesy is important to you, inform the patient's insurance company and get the company's consent though the paperwork involved might change your mind. You also need to satisfy the insurance company that you are not extending professional courtesies for referrals.

"It's important for physicians to know that there are risks out there, and if this is a long-standing policy that their practices had, they might want to take another look at it now." — Jan Leibovitz Alloy

Take Action

For more information, contact Nancy Brigner, (614) 462-5015.



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Dateline Ohio

Minority physicians protest cuts from Anthem's panels

Anthem Blue Cross and Blue Shield's decision to drop two Cincinnati African-American orthopedic surgeons from its managed-care panels has raised concerns about whether or not racial diversity exists in a managed-care environment.

The two physicians, were dropped "without cause" from the health plan panels. They are the only African-American orthopedists in Cincinnati. There was no charge of racism against

Anthem, but the Cincinnati Medical Association (CMA) said most health plans are not sensitive enough to African-American patients, who generally prefer African-American doctors. African-American physicians argue that managed care's preference in working with large physician groups tends to hurt black doctors who are often solo practitioners.

In response, Anthem says it does not keep information on providers' sex, race, ethnic background or nationality so those factors are not considered when changing or refining a panel. Nevertheless, Anthem has created a task force to address issues of cultural diversity in managed health-care networks. Among other things the task force will develop a means of tracking demographic information, so that cultural diversity can be considered in the future in developing its provider panels. Russ Dean, executive director of the CMA, will serve on the

task force.

In addition, the CMA's Physician-Patient Advocacy Committee is reviewing the issue.

There are currently no laws in place that prevent plans from terminating physician contracts without cause, however, under the Physician Health Plan Partnership Act, plans are required to provide contracting physicians an opportunity to correct performance problems whether quality or utilization, before termination.

The OSMA is monitoring how health plans terminate physicians to ensure that physicians have been given an opportunity to correct or improve actions. If plans continue to terminate physicians "without cause" the OSMA says this would violate the good-faith agreement reached when the bill was passed. If necessary, the OSMA says it may pursue additional legislation to correct the "termination without cause" issue. ■

HMOs face financial woes

State legislators have said health maintenance organizations may continue to call themselves HMOs (instead of their official legal name, HIC for health insuring corporations), but when it comes to HMOs participating in the state's Medicaid program, there will be a second look at the financial problems they are experiencing – by whatever name.

Five of the 13 Medicaid HMOs reported third-quarter losses, and some HMOs have pulled out of the program.

Sen. Roy Ray, Senate Finance Committee chair, told the *Ohio Health Care Report* that an interim rate increase is "imminent," but that the amount will be small, maybe 2.5% to 3%.

Meanwhile, base capitation rates for Medicare HMOs increased 2%, with the possibility of further rate adjustments during this congressional session. ■

The latest Cleveland Health Quality Choice Program report card, released in December, shows a wide variation in how long patients are hospitalized but little difference in patient death rates.

The semi-annual report card studies the quality of care at 27 Cleveland hospitals and contains full information on intensive-care patients.

The December report showed that 16 of 27 area hospitals had patients staying longer than expected, based on the severity of their illness. Still, the

Compensation for mid-level providers is increasing

Income levels for allied practitioners (mid-level providers) rose significantly in 1997, due, in part to the increasing demand for primary care "gatekeepers," says the Physician Compensation and Productivity Survey, conducted by the Medical Group Management Association (MGMA).

The annual survey, funded by Cejka & Company, includes information from more than 1,600 group practices and 35,000 physicians and mid-level practitioners.

The three mid-level professionals earning the highest incomes were:

- Nurse-anesthetists. Salary is up 5% from \$79,002 to \$82,952.

- Nurse practitioners. Salary increased 3.6% from \$50,910 to \$52,788.

- Physician assistants. Surgical PAs' salary is up 6.86% from \$63,589 to \$67,953. Primary care PAs saw a 1.69% increase in salary, up from \$56,249 to \$57,200.

"There is an increasing trend towards the use of mid-levels, and a broadening of their scope of responsibilities," says Cejka, president of the firm that funded the survey. Many of these professionals, the survey says, are joining forces with primary care physicians to form health-care teams composed of a physician, physician assistants, specialized nurse, social worker, nutritionist, or public health aide.

"In markets with high levels of managed-care penetration, we see one mid-level recruited for every two physicians in primary care specialties," says Cejka. "This is a dramatic increase from previous staffing levels. Mid-level compensation is being moved from flat salary compensation to a productivity-based compensation, similar to that of physicians." ■

OSMA News

Resolutions due March 15

How to submit a resolution

If you have a resolution to present to the House of Delegates, you must have it in to the OSMA by March 15. OSMA bylaws require that resolutions be submitted to the executive director at least 60 days before the opening of the Annual Meeting. This year's meeting runs May 14-16.

OSMA Meeting Manager Susan Paulus invites members to submit resolutions before the deadline. "We have to get them out to active members at least 30 days before the meeting," she says. "We try to get them in earlier so we can publish them in *Ohio Medicine*."

Guidelines

To simplify deliberations of the House of Delegates, the OSMA has developed guidelines for preparing a resolution:

- Give the resolution a title that indicates the action you want the House of Delegates to take.
- Thoroughly check the accuracy of all quotes, references to other actions, statistical information, and other supporting data included in your resolution. Provide clear citations to the sources of your data, in footnotes if possible.
- Check your spelling, grammar, and sentence syntax to ensure that the intent of your resolution is clear.
- Write the "Resolved" section so it can stand alone. Although the "Whereas" section must also be clearly worded, the House of Delegates adopts only the "resolve."
- Attach fiscal notes, even if the amount is small. Rarely can a resolution be put into effect without expenditure of some kind.

- Make sure your resolution is complete, including the title, sponsor, and fiscal note.

Sample resolution

A resolution on increasing membership might read like this:

Submitted by:
OSMA Council

Title: Membership
Campaign

Whereas, The Ohio State Medical Association is the only statewide medical association capable of speaking for all Ohio physicians; and

Whereas, OSMA members have urged that all Ohio physicians become involved in the activities of organized medicine; and

Whereas, There are several thousand physicians who do not belong to OSMA;

Therefore be it

Resolved, that the OSMA make every effort to speak for all Ohio physicians by inviting nonmembers to become involved in organized medicine and that a formal membership campaign be developed to encourage non-members to join the OSMA.

Fiscal Note: \$5,000.

"Survey Results: OSMA Members Voice Ideas, Problems, and Opinions," *Ohio Medicine*, September 1995.

Statistical Analysis, Department of Finance, OSMA.



New members can now join OSMA for less

Nonmember physicians can join the OSMA at a new discounted rate. The association now offers 50% discount on dues to new members in their first year of membership, and a 25% discount in the second year. The offer is open to any physician who has not been an active member of the OSMA in the past. Former medical student and resident members are eligible for the discount program as well.

Dues rates in the new program are \$232.50 for the first year of membership and \$384.75 in the second year. Full dues, \$465, are paid in the third and subsequent years.

If you have a colleague, or know a physician who is not a member of the OSMA, and never has been, tell them about the new discount membership program — and the benefits organized medicine provides the practicing physician.

No second guessing

Your resolution will be returned if you fail to follow the guidelines, Paulus says. "The intention of your resolution must be clear, concise, and well documented," she says. "The resolutions committee and the House of Delegates can't second-guess what the writers intended." — Jan Leibovitz Alloy

Take Action

For more information, contact Susan Paulus, OSMA meeting manager, (800) 766-6762, mtgmgmt@osma.org.

The Action Report on 1998 resolutions is due out soon.

Last year's delegates and alternates will receive copies. If you would like a copy, contact your county medical society. For questions, contact the OSMA Department of Meeting Management at (800) 766-6762.



Take Action

If you have questions about the new program, or would like to brush up on OSMA's benefits and services, contact Doug Evans, director, Division of Membership Services, at (800) 766-6762, Ext. 6774, or e-mail: devans@osma.org

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CME featured opportunities

These two CME programs are among many courses offered by the more than 70 sponsors of CME accredited by the OSMA.

Anxiety and Panic Disorder

When: Feb. 24

Sponsor: Robinson Memorial Hospital, Ravenna, and supported by an educational grant from Alta/Pfizer, Inc.

Speaker: Joseph Locala, MD, Department of Psychiatry, Cleveland Clinic.

Objective: To help family practice and other physicians differentiate panic disorders from other disease states, identify related medical conditions, and develop treatment plans.

Time: 8 - 9 a.m. at Robinson Memorial Hospital.

For further information contact:
Pat Dias (330) 297-2540.

CME credits: 1

Emergency Management Seminar

When: March 10

Sponsor: Lake Hospital System, Painesville.

Objective: To update primary-care physicians and ancillary health professionals on treatment of hydrofluoric acid burns, management of acute coronary syndromes, drug toxicity, animal bites and stings, and dermatological emergencies.

Time: 7:30 a.m. - 12:30 p.m. at Radisson Hotel and Conference Center, Eastlake.

For further information contact:
Jan Krehel (440) 953-6216.

CME credits: 4



Physician's CME Recordkeeping Folder

The Ohio State Medical Association is recognized by the Accreditation Council for Continuing Medical Education (ACCME) to accredit sponsors of Continuing Medical Education (CME) programs within the state. This recognition allows the OSMA to provide physicians with local/regional opportunities to gain CME credit to fulfill the State Medical Board of Ohio Doctor of Medicine licensure requirements. It is through the support of physician membership that the OSMA is able to offer voluntary accreditation to institutions and organizations whose interest is in providing educational offerings which meet the OSMA's high level of quality. The direct result is convenience to members of the OSMA giving you the opportunity to complete licensure requirements through local and regional CME activities.

This organizational folder is an important part of the OSMA's efforts to serve the physicians of Ohio. It has been developed to help physicians understand state CME rules and to keep their records of attendance. It contains brief information on the mandatory CME requirements and a table which outlines the number of CME hours required for the staggered license renewal system that went into effect July 1998. CME requirements are imposed by Ohio law as enacted by the Ohio General Assembly.

Categories of CME

CME consists of two categories as defined by the American Medical Association, Category 1 and Category 2 as described on the inside of this folder.

In recording your CME, keep in mind that Category 1 CME is designated by an accredited entity of CME. The accredited entities provide physicians with verification of Category 1 credit as defined under "Acceptable Documentation." This documentation of Category 1 CME credit can be stored within the OSMA's Physician's CME Recordkeeping Folder. Category 2 CME (either designated or self-claimed) can be logged directly on the folder (see section under Category 2).

(Continued on page 2)

The State Medical Board's Staggered License Renewal

First initial of licensee's last name	License expiration date	New CME Cycle	Pro-rated CME hours needed
A-B	7/1/01	7/1/98 - 4/1/01	137 hours (55 Cat. 1)
C-D	4/1/01	7/1/98 - 1/1/01	125 hours (50 Cat. 1)
E-G	1/1/01	7/1/98 - 10/1/00	112 hours (45 Cat. 1)
H-K	10/1/00	7/1/98 - 7/1/00	100 hours (40 Cat. 1)
L-M	7/1/00	7/1/98 - 4/1/00	87 hours (35 Cat. 1)
N-R	4/1/00	7/1/98 - 1/1/00	75 hours (30 Cat. 1)
S	1/1/00	7/1/98 - 10/1/99	62 hours (25 Cat. 1)
T-Z	10/1/99	7/1/98 - 7/1/99	50 hours (20 Cat. 1)

The categories of acceptable CME for licensure are based upon those outlined in the American Medical Association Physician Recognition Award (PRA) booklet.

Authority & Responsibility of CME Credit

Only institutions accredited as CME sponsors by the Ohio State Medical Association (OSMA) or the Accreditation Council for Continuing Medical Education (ACCME) may designate a CME activity for credit. Accredited entities are responsible for understanding CME credit requirements and have the authority to determine which of their activities meet these requirements. Regardless of the amount of credit specified by the accredited institution, each physician should claim only those hours actually spent participating in the educational activity or studying the materials.

Category 1 (CME activities with accredited sponsorship)

DEFINITION: Category 1 activities are those planned CME activities sponsored by an organization or institution accredited by the ACCME or the OSMA.

Category 1 activities must meet specific criteria outlined below:

- It conforms to the AMA definition of CME;
- It is based on perceived or demonstrated educational need;
- Brochures for the approved CME activity include the learning objectives;
- The content is appropriate for the specified objectives;
- The teaching/learning methodologies and techniques are suitable for the objectives and format of the activity;
- Evaluation mechanisms are defined to assess the quality of the activity and its relevance to the stated needs and objectives.

Value: One credit for each hour of participation.

ACCEPTABLE DOCUMENTATION

- Hospital or institutional computer listings, e.g. grand rounds, teaching rounds and seminars. Listings must indicate that the activities have been designated for Category 1 credit.
- Signed application of AMA Physicians' Recognition Award. (Dates must coincide with the board's audit period.)
- American Academy of Family Physicians (AAFP) computer printout.
- American College of Obstetrics and Gynecology (ACOG) computer printout.
- Activity certification or letters. Documentation must show name of activity, sponsor, doctor's name, dates, number of hours and indication of accreditation.
- Letters from residency or fellowship program. Documentation must show dates of participation and name of doctor.

Category 2 (CME activities with nonaccredited sponsorship)

DEFINITION: Includes CME activities with nonaccredited sponsorship; medical teaching; articles, publications, books and exhibits; nonsupervised individual CME activities; and other meritorious learning experiences. To ensure proper documentation physicians should record the type of Category 2 activity, date, time spent, location, description and other pertinent information in the folder under Category 2. Credits in Category 2 may be achieved in any one or more of the following areas:

CME Activities with Nonaccredited Sponsorship

Criteria: Credit in Category 2 may be claimed for CME activities that either do not have accredited sponsorship or do not meet the definition of a planned program of CME; however, they must meet the definition of CME. Activities sponsored by an accredited organization that do not meet the definition of a planned activity may be claimed in Category 2.

Value: One credit for each hour of participation.

Medical Teaching

Criteria: Credit may be claimed for contact hours of teaching, including lecturing to medical students (including preceptors), residents, practicing physicians and other health professionals.

Value: Ten credits for each hour of teaching. One credit for each hour as preceptor.

(Continued on back page)

**Place your Category 1 documentation in this folder and record
Category 2 activities on this page.**
(Submission of this folder does not meet relicensure requirements.)

Category 2

Physicians are responsible for keeping evidence of their CME activities for six years in the event they are audited by the State Medical Board.

Articles, Publications, Books and Exhibits

Criteria: Credit may be claimed for a medical or medically related article, publication or for each chapter of a book that is authorized and published. A paper must be published in a recognized medical journal.

A presentation of an exhibit must be offered to a medical audience, which can include allied health professionals. Credit may be claimed only for the first time the materials are presented and should be claimed as of the date the materials were presented or published.

Value: Ten credits for each presentation or publication.

Nonsupervised CME Activities

Criteria: CME activities that are not directly supervised.

- **Self-instruction:** Self-instruction materials and CME activities claimed in Category 2 need not be produced, sponsored or joint-sponsored by an organization accredited for CME, nor are they required to meet the definition of a planned activity of CME.
- **Consultation:** The education a physician receives from a consultant can be claimed provided the consultation is expanded to meet the definition of a planned activity of CME. The instruction period should not be less than one hour. Ordinary case consultation should not be claimed. In recording, the name of the consultant(s) and the topic discussed should be given.

When an individual instructor offers a CME course, physicians attending the course may claim hour-for-hour participation. The consultant or instructor may claim credit for medical teaching.

- **Patient Care Review:** Credit may be claimed for participation in activities for review and evaluation of patient care. This includes such activities as peer review, medical audit, consecutive case conferences, chart audit and participation in a Professional Standards Review Organization (PSRO) where participation involves patient care review or the development of screening criteria or norms.

Physicians attending courses dealing with the methodology for evaluation of patient care should claim credit in Categories 1 or 2 according to the designation statement. Service on hospital medical staff committees for tissue review, infections, death conference, pharmacy, etc., may also be claimed when they consider any aspect of medical care.

- **Self-Assessment:** Credit may be claimed for time spent in taking a self-assessment examination. To be acceptable, the examination must be scored and the results made known to the participants so they may plan CME activities based on the CME needs so identified. Time spent by the physician taking so-called self-tests that may appear as pretests, or pretest/posttests in medical publications should not be claimed in any category.

CME completed by a physician in preparation for a self-assessment examination should be claimed in the category for which it is designated or for which it qualifies.

Value: One credit for each hour of participation.

Other Meritorious Learning Experiences

Criteria: This includes CME activities and experiences that are not appropriate for any of the other categories. If possible, an accredited organization should be involved in planning, coordinating, administering and evaluating the CME activity.

Answers should be provided to the following questions:

1. What CME need was this experience designed to meet?
2. How was this CME need determined?
3. What was the educational objective(s) and what was the knowledge level or skill that was achieved?
4. What were the activities that were used to meet this objective?
5. What educational techniques were used in the CME activity?
6. Who was the instructor and/or the sponsoring educational institution?
7. How was the experience evaluated in terms of meeting the educational objectives?
8. How many hours of CME were accumulated, what were the dates and where was it held?

Value: Dependent on responses to questions 1-8. Maximum of one credit for each hour of participation.

For complete licensure requirements:

Ohio State Medical Board
Medical Records Department
77 S. High St., 17th Floor, Columbus, OH 43266-0315
(614) 466-3934

For information regarding CME:

Ohio State Medical Association
Office of Continuing Medical Education
3401 Mill Run Dr., Hilliard, OH 43026
(800) 766-6762 or (614) 527-6762

Here's how the Medical Board's staggered license renewal plan works

"I just want to be sure I have the right number of CME (continuing medical education) units for renewal, that's all," is a common sentiment among physicians trying to decipher the new staggered renewal system. Admittedly, the current transition can be confusing, but it's important for you to understand, not only why the system was created, but how the transition will affect your license.

Here's the reason

A budget bill passed in Ohio authorized the State Medical Board of Ohio (SMB) to implement a staggered medical license renewal system beginning in March of 1998. This means that instead of every physician renewing their license at the same time, every two years, renewals will be spread out so that every quarter, a different group of renewals will be due.

This process will provide a constant stream of revenue for the SMB, rather than providing one lump sum every two years. It results in more autonomy for the SMB, makes them more fiscally responsible, and allows their work load to be leveled.

A fact sheet was assembled by the SMB and sent out with the July 1, 1998 renewal date application kit.

According to Debra Jones, chief, CME, records and renewal at the SMB, "Some recipients of the information about the staggered plan had questions about why it is being done. Others read the fact sheet sent out with renewal notices and didn't understand how it would affect them, personally."

Here's how it works

The actual implementation of the staggered license renewal plan began in March 1998. All MDs, DOs, and DPMs (podiatrists) licensed by the SMB have received individualized CME requirements and prorated fee information based on the first letter of their last name. Each practitioner falls into one of eight groups, each group requiring renewal during a different quarter of the year over a two-year period. During the present transition to

the new system, most physicians will have a required number of CME credits that departs from the usual 100 hours per renewal period. License fees will also be an unfamiliar amount for most practitioners.

Like any prorated system, there is a target date for full implementation – April 1, 2001. To switch everyone over to the new system, the amounts of CME credits earned and the fees will vary according to the length of time before another renewal is required. By the time the entire transition process is completed, all licensees will have needed the same amount of credits and paid the same amount of fees. In other words, these items are adjusted, temporarily and proportionately, until everyone falls into the new renewal schedule.

For example, physicians with last names beginning with A - B wait all the way to July 1, 2001 before they must renew their license, but must acquire 137 CME hours and had to pay \$371 for their previous renewal on July 1, 1998. Physicians with last names T - Z will renew their licenses again on July 1, 1999 date, but require 50 hours of CME and paid only \$147 in fees during the present renewal period. After this one round of various fees and CME credits, everyone will be on the new schedule, and all credits and fees will be the same for everyone.

There are some details required to make the transition work. For example, "If a physician has had a name change, for renewal purposes, they stay under the name that appears on the originally-sent renewal notification or with whatever name they were using on March 1, 1998," explains Jones. In other words, a name change will not move you to a new group in the future.

Related to CME credits, partial exemptions are possible for individuals who have been ill or out of the country for more than six consecutive months during the registration period, says Jones.

To ease the transition, the OSMA is providing a new CME Recordkeeping Folder tailored to the current transi-

tional period. The folder is attached in this issue of *Ohio Medicine*. A chart summarizing the new renewal fees and CME hour requirements is provided on the folder's first page. Physicians are responsible for maintaining their own records of CME.

Meanwhile, to ease the transition and time crunch that could pressure some physicians to get their CME credits, the OSMA is encouraging CME sponsors to provide adequate opportunities during the staggered license renewal transition. – Yvonne H. Berry

Take Action

For further information, the medical board has produced a booklet on CME under the new system. For a copy of the booklet, contact the Ohio State Medical Board at (614) 466-3934 or visit their Web site at: www.state.oh.us/med. For questions about CME requirements or to obtain a list of CME opportunities in Ohio contact the OSMA Department of Continuing Medical Education and Outcomes Research at (800) 766-6762.

What happens if you are audited by State Medical Board?

"The State Medical Board of Ohio (SMB) audits some physicians' CME records to ensure compliance and appropriate documentation of their continuing medical education (CME)," says Thomas A. Dilling, SMB government affairs officer. The physician's signature required within the license renewal vouches that the continuing medical education credits are correctly attributed. "If they sign it and don't have the CME, they have 'signed a fraudulent statement,'" says Dilling.

Dilling explains the audit process like this: Failure to sign the CME voucher disallows the right to practice. The voucher must be signed if the physician wishes to continue practice. If an audit shows a discrepancy or deficit, there is a hearing. If a problem is verified, the punishment could be a reprimand or a 30-day suspension of license. Starting March 1, 1999, a new law further allows the medical board to fine up to \$5,000 for failure to complete the required CME.

With the staggered renewal plan now being implemented, the threat of an audit may be of greater concern. SMB Rule 4731-10-08A (2) states that license applicants obtain written confirmation of both Category 1 and 2 CME hours and retain that verification for one year after the end of the registration period or staggered registration period.

As such, the OSMA recommends careful recording of CME credits in the "Physician's CME Recordkeeping Folder" provided in this issue of *Ohio Medicine*. CME Program regulations are also summarized within the folder. – Yvonne H. Berry

Help needed for women's health initiative

The OSMA Committee on Education is seeking medical specialists in two areas to help with the educational, two-year Women's Health Initiative that the OSMA will launch this spring.

Specialists in osteoporosis and breast cancer are needed to serve on an advisory group to review and/or develop educational material for Ohio physicians.

Members of the osteoporosis advisory group will review materials for a handbook that will focus primarily on screening and other preventive measures.

Breast cancer specialists will review materials for an interactive Web-based continuing medical education module on the topic of breast cancer. The program will focus on the area of communication and risk management, and, once developed, will be made available to physicians over the Internet, as well as in hard copy. This is a joint educational project between the Ohio Department of Health and the OSMA.

Take Action

If you would be interested in serving on either of these advisory groups, or would like more information about them, contact Janet Shaw, director, OSMA Department of Continuing Medical Education and Outcomes Research (800) 766-6762, Ext. 6737, e-mail: cme-outcomes@osmo.org.

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Please send CV to: Gary LeRoy, MD, 2132 E. Third Street, Dayton, Ohio 45403; or fax to (937) 208-6866.

Utlak's presidency to start at 1999 Annual Meeting

David J. Utlak, MD, will be installed as the new OSMA president during the Opening Session of the 1999 OSMA Annual Meeting. The meeting, May 14-16 in Cincinnati, will follow the shorter, more streamlined format adopted during last year's Annual Meeting.

District caucuses, starting at 7 a.m. Saturday, will precede the 10 a.m. opening session. The resolution committee will meet from 1:30-5 p.m. If needed, district caucuses will follow the resolution committee hearings. The



David J. Utlak, MD

remainder of the day will be spent preparing resolutions reports and conducting candidate interviews. A presidential reception is at 7 p.m.

On Sunday, district caucuses will begin at 7 a.m. The Final Session of the House will follow at 10 a.m.

OSMA members also may attend the Organized Medical Staff Section Meeting from 1-5 p.m. Friday.

The deadline for resolutions is midnight March 15. (See page 11 for information on how to write a resolution.) Resolutions must be mailed to: Brent Mulgrew, Executive Director, Ohio State Medical Association, 3401 Mill Run Drive, Hilliard, OH 43026.

For more information, contact Susan Paulus, Annual Meeting coordinator, at (800) 766-6762 Ext. 6727. ■

Schedule of Events

Friday, May 14	
8 a.m. to noon	OSMA council meeting
1-5 p.m.	Organized Medical Staff Section Meeting
4-5 p.m.	New delegate briefing, emergency resolutions meeting, OMERF board meeting
5-7 p.m.	Possible district caucuses
Saturday, May 15	
7-10 a.m.	District caucuses
8 a.m.	Registration, House of Delegates
8-10 a.m.	Educational session
10 a.m.	Opening Session, Presidential installation
1:30-5 p.m.	Resolutions committee hearings
3-5 p.m.	OMPAC board meeting
4:30 p.m.	Resolution report preparation
4:30-6 p.m.	Candidate interviews
4:30-7 p.m.	Possible district caucuses
7-9 p.m.	Presidential reception
Sunday, May 16	
7-10 a.m.	District caucuses
8 a.m.	Registration, House of Delegates
10 a.m.	Final Session, House of Delegates
4-6:30 p.m.	OSMA Council meeting

AMA report

AMA challenges Aetna-Prudential merger

The American Medical Association (AMA) is concerned about the recent Aetna-U.S. Healthcare/Prudential Insurance merger, and has sent a note to the U.S. Justice Department's Antitrust Division, calling on the division to challenge the merger as anticompetitive.

"The market power that would be created or exacerbated by this merger would limit the choices of patients and employers, reduce competition and further erode the ability of physicians to make medical decisions based on science and the medical needs of their patients, not share price," AMA Executive Vice President E. Ratcliffe Anderson, Jr., MD, wrote in the letter to division chief Joel Klein.

The letter is the AMA's latest effort in an ongoing AMA campaign aimed at correcting and exposing managed-care abuses. ■

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Physician: Look to your image

During the AMA's interim business meeting in December, several areas of professional ethics came under discussion, including whether or not the AMA should release information on physicians' income.

Those who know me know that I have some concerns on this subject. As physicians, we need to strike a balance between the compensation we receive for all the good things we do for our patients, and the obligation we have to pay something back to society, either in monetary terms or in terms of our time and service.

It's a fine line to walk, to be sure, and some are better than others at finding and keeping a balance. After all, we need reliable cars, our families are entitled to comfortable homes (since we're often not there to share it with



Lance Talmage, MD

President's Perspectives

them), and I learned the hard way about the need to take adequate vacation time. Early in my practice, I took some time off for CME opportunities and military obligations, and then found myself working six months straight without any time off. Needless to say, my disposition during that time left something to be desired.

Compensation has dropped for many of us in the last few years, but it is still well above average. Fortunately, we are held to a higher standard of behavior than entertainment and sports millionaires. Our respect depends on our ethics in business matters and minimal public whining about income.

There are plenty of opportunities to

give your time, money and talents to others, both inside and outside your community. I know of physicians who volunteer their time to serve charity and cultural organizations at home, as well as those who travel abroad, lending their medical expertise to individuals in areas where health care is generally inadequate compared to American standards.

If you are thinking this has to do with our professional image, you're right. In fact, image fits into another discussion that was raised at the meeting, one that, unfortunately, has a local connection: the ethics behind intimate relationships formed, not with patients (that matter has been discussed already, and AMA policy formed), but with family members of patients.

Like it or not, physicians present a certain image of power and control in their relationship with patients. That's why we must be careful to avoid even a suggestion of impropriety when we extend our services to others. If a pa-

tient, or a member of that patient's family, believes his or her response to a request for sexual favors (or any other favor) will influence the care the patient receives, then a great disservice has been done to the profession, and to the image of physicians everywhere. Be careful not to involve yourself in what may be, ultimately, a matter of control.

As physicians, we need to maintain a professional image, whether that's in a physician-patient relationship, in our communities, or in the world. That's the bottom line, really, in any discussion of professional ethics. Image is about character. And character is perhaps the most important asset we can have...as a nation, as a profession, and certainly as an individual. ■

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Practice Tips



Coding concerns

Consult/referrals may be biggest problems of E&M guidelines

While no one knows, yet, what the final form of the new Evaluation and Management (E&M) documentation guidelines will take, there is still plenty of confusion surrounding the 1994 and 1997 versions, says Jillian Phillips, MA, CCS-P, CPC, certified coding consultant in the OSMA Department of Ombudsman Services.

Phillips presented seminars across Ohio last fall that tackled the thorny guidelines – and how to tame them. “The number one question I was asked at each seminar is ‘What is the difference between consults and referrals?’ she says.

The difference, she explains, is crucial. Just try using the consult code without the necessary documentation to support it and, suddenly, you’re downcoded to an office or other service.

CPT definition of consult

In CPT terminology, a “consult” is defined as a request for opinion/advice only by one physician (usually a specialist) of another. You say, but that’s not the way we used the term in medical school. This is where it gets tricky. To use a consult code, you:

- see the patient who is sent to you;
- assess the patient and the problem, possibly using diagnostic lab or procedures to do so;
- give your opinion/advice to the primary physician, who then;
- makes the final decisions whether or not to release the care of the patient to the consulting physician if medically indicated.

“Without evidence of that back-and-forth exchange between you and the referring physician, the consult will be downcoded,” says Phillips. In other words, you need to be in close communication with the primary physician to know how to code properly. The patient who shows up in your practice may have been sent there for an opinion or advise (consult). “Or the primary physician may have sent that patient to you for treatment,” says Phillips. You’ll need to know before you can code your service appropriately.

“It comes down to a communications problem,” says Phillips. “Often, physicians don’t keep each other informed of the nature of the request.” The solutions? Talk to each other, and, if the service is a consult – the CPT definition of that word, that is – then be certain the primary physician has documented your advice before that patient arrived at your door for treatment.

Also, there is the additional confusion concerning that treatment may be initiated at the initial consult. But, after that, the patient must be sent back to the primary care physician, who then must decide whether treatment should be continued by the consultant, if that is the advised course of care. If the consultant decides on his or her own to treat without the primary physician’s permission, then it’s not a consult, says Phillips.

Complex system

The number two concern of seminar attendees, Phillips reports, is the incredible complexity of the guidelines.

The guidelines have come a long

way since the American Medical Association (AMA) originated them at the request of physicians who wanted specific guidelines on how to code for reimbursement. Now, the guidelines have become difficult to follow.

“Everyone finds them difficult to understand,” says Phillips. That’s because the E&M guidelines consists of three parts: history, exam and medical decision-making, and the history and medical decision-making each have three parts of their own. No wonder, then, that attendees said they had no clear understanding of how to find the correct level of service.

“I tell them, first, treat the patient,” says Phillips. “Document second. After that, they should find the level of service.” But she warns, that isn’t easy.

“It involves a lot of counting, and the physician really needs someone in his or her office who can do that full time. Gone are the days when one could just look at a medical record and determine the level of service just by sight.”

Full-time person or not, don’t forget that, ultimately, you are the person responsible for the codes you use, so you do need to understand them properly.

Counting to stay

If you have avoided coming to grips with the 1997 guidelines because new – and maybe better ones – will be coming along, Phillips has bad news. “The new guidelines will probably follow the format of the ‘97 guidelines,” she says. That means lots of counting.

Despite pleas from the medical community late last year to eliminate counting, the Health Care Financing

Bucking Medicare’s bureaucracy

At least one Ohio physician has decided to avoid the paperwork and potential fraud and abuse charges posed by the Medicare system, by treating all of his current Medicare patients – for free.



Nino M. Camardese, MD

Camardese, MD, a Norwalk family physician and an OSMA member, says that Medicare patients now comprise over half of his medical practice, although he stopped accepting new Medicare patients over a year ago.

In exchange for the free treatment, Dr. Camardese is asking Medicare patients to make donations to three educational organizations: The Americanism Foundation; the Freedom in Medicine Patient-Physician Coalition Education Foundation; and the Born Again American Foundation, all centered in Norwalk.

Giving away his medical care “relieves the horrendous fears, oppression and threats from government bureaucracy,” says Dr. Camardese.

“Do you realize that, for a minor, inadvertent, unconscious numerical error I could be punished by fines or jail or both?” Dr. Camardese asks.

He challenges other Ohio physicians to join him in his efforts.

For more information contact Dr. Camardese at (419) 668-8282 or fax (419) 668-8283. ■

continued on page 18

E&M

continued from page 17

Administration (HCFA) has already said that counting will be a part of the new guidelines whenever they appear.

"That's why the 1997 guidelines are important," says Phillips. They familiarize you with how to count. "Counting isn't going to go away, so you need to learn how to do it," she adds. Don't forget that technically, the old '94 guidelines are also still in effect, and audits are conducted using both the '94 and '97 guidelines.

The OSMA and Phillips will offer you opportunity to learn about counting and other aspects of E&M documentation later this year, when new E&M documentation seminars will be offered. If you missed them this fall, make a point to sign up for them this year so you'll be ready whenever HCFA introduces the new guidelines.

Watch also for other educational seminars on coding, says Phillips. "I'll be offering half-day seminars on ICD-9-CM coding, and coding CPT that deals specifically with some of the specialties, like surgery and radiology."

Phillips is also available to help you or your office staff with coding questions and concerns. You can reach her through the OSMA Department of Ombudsman Services. Coding questions are best handled when they are in writing and faxed to her attention: (614) 527-6763. ■

Medicare forms available

If you need a copy of any of the following Medicare fee schedules, you may obtain them through the OSMA Department of Ombudsman Services. Call Cathy Sonnhalter, (800) 766-6762, Ext. 6759 for a copy. They are free to OSMA members:

- Clinical lab fee schedule
- Drug/Biological fee schedule update (J-Codes)
- Ohio Medicare fee schedule.



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Medical-equipment problems are possible

The Y2K (Year 2000) Bug that everyone is talking about refers to the fact that some computer software and embedded computer chips may not properly recognize the new date, and certain other "nearby" dates, such as 1/29/2000 and 09/09/99.

Age of equipment is not a guarantee of its "year 2000 compliance." The Veterans Health Administration (VHA) reports that only 50% of computer equipment sold in 1997, and only 75% of that sold in 1998, is compliant.

What could go wrong

According to AMA Trustee Donald J. Palmisano, MD, JD, who has been actively involved in education and testimony about Y2K, very specific medical-equipment problems are possible. For instance, a date-reading error could result in a portable defibrillator/EKG monitor shutting down when its "brain" decides that the machine has a major malfunction, or

alarms may not sound in cardiac monitors when patients' pulse rates are dangerously low or high, or radiation dose calculations for tumor destruction may adjust too high or too low.

He also notes that medical records and billing programs on information systems with Y2K incompatibility have the potential to disrupt retrieval of medical records and reimbursements, with significant adverse consequences.

Medical facilities will want to confirm compliance throughout their physical plant, such as elevators, HVAC (heat, ventilation and air conditioning), security systems, telecommunications and vehicles. Virtually all businesses also depend on vendors such as banks, utilities and payroll companies.

The health-care industry challenge will be shared by hospitals, outpatient clinics, physicians' offices, laboratories, pharmacies and patients' homes. As our economy has become more complex and global, we have become

more interdependent, increasing the risk of failures in a vast delivery chain we've come to take for granted.

Guides, seminars available

Fortunately, as the countdown to the year 2000 continues, more useful information and tools are becoming available for thoroughly assessing the Y2K compliance of medical device inventories.

A practical, readable and free guide that is applicable to any size health-care facility has been produced by the VHA, which manages one of the largest medical systems in the world. *The Year 2000 Medical Device Assessment Guidebook* includes an ongoing procedure for tracking and assuring that corrective actions are taken when required. Available online or by phone.

The FDA, in cooperation with the VHA, provides an online national clearinghouse containing the compliance status of medical equipment, as reported by each manufacturer (see

Resources). The list includes manufacturer Web site addresses, contact names and phone numbers and links to other Year 2000 health-care Web sites.

According to Leonard Bourget, VHA Year 2000 project manager, biomedical engineers at the VHA and at the nonprofit, health-care technology research agency ECRI have "a great deal of confidence in the compliance reports, based on the fact that health care is a regulated industry and on manufacturers' past behavior under hazard alerts. Where information is made available from the manufacturers, neither agency will be self-testing."

Bourget summarized the present compliance list as "82% compliant, and of the remaining 18%, most are being repaired by the manufacturer. Very few — about 4% — are being abandoned as not convertible. Also, we have received responses from 96% of the 1,467 manufacturers contacted."

Health-care-oriented Y2K seminars are available through both ECRI and AMA (see Resources.) — Carol Larimer

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Resources

- *The Year 2000 Medical Device Assessment Guidebook* is available from www.va.gov/y2k/2000/ymdguide.pdf. (To read this file, you must have Acrobat Reader, available free online at www.adobe.com/prodindex/acrobat/readstep.html.) Limited quantities of the guidebook are available by calling (202) 273-8743.

- The "Biomedical Equipment Year - 2000 Status Database" is available at www.tda.gov/cdrb/yr2000/y2kintro.html.

- ECRI Y2K Interactive Telephone Seminar Series call (610) 825-6000, Ext. 5888.

- AMA Y2K seminars, set for Atlanta, Boston, Denver and Phoenix, call the AMA Member Service Center, (800) 262-3211.

- The AMA "Preparing for the Year 2000" site: www.ama-assn.org/notmo/y2k/index.htm.

How to use practice profiling to your advantage

More than 75% of managed-care plans profile physicians. For most physicians, that's not necessarily good news, but according to a former medical director of a managed-care organization, you can use practice profiling to your advantage.

As you already know, your profile is relevant because it may affect your ability to:

- join a group practice, a medical staff or a managed-care plan;
- become recredentialed or reappointed;
- compete effectively for patients.

It could also have a significant impact on your rate of reimbursement. Nearly one-third of all health plans, and more than one-half of the network models, use patient satisfaction surveys as a factor in payment to doctors. And two-thirds of network models use adherence to quality guidelines as a component of payment.

To profile your practice, plans gather information from claims data, medical records, patient surveys and health-risk appraisals, and use that data to identify variations in physician practices.

"The information, if it is accurate, can be used to move toward better management practices," says Linda Yazvac, MD, former medical director for Cigna, and now principal of Yazvac & Associates, consultants in quality improvement and managed care. "Your profile will help you identify your practice's areas of strengths and weaknesses. Performance profiling can help you take the pulse of your practice. It can show you how to work smarter, not harder."

Accessing and using your profile

If you approach your plan's medical director from the perspective of practice improvement, that individual will probably be glad to personally go over your profile with you. You will want to know the plan's formulas and method-

Improve your practice through profiling

• Review your profile...Your plan's medical director will probably be glad to review your profile with you.

• Ask questions...Learn the data sources used for your profile, and the time period reflected.

• Check for errors...If the information doesn't seem accurate ask for more details. Correct any erroneous information.

ologies for deriving and interpreting each area of information, in case your practice is an outlier (outside the norm) for a very specific reason, says Dr. Yazvac.

She recommends that you learn the data sources used and time period reflected. In addition, ask these questions: What was the denominator used to compute your performance? What were the severity adjustment and method? What patient list was used? Was detailed back-up information obtained?

Review your profile carefully, and ask questions if you're unclear about something. If the information doesn't seem accurate, ask for more details. Correct any erroneous information. And consider requesting a meeting to discuss findings if you are an outlier.

"The medical director may even share with you the names of other physicians in practices similar to yours with whom you could speak about differences in your practices, in order to improve yours," says Dr. Yazvac.

Most physicians in Ohio are still in solo practices, or in groups smaller than five. In fact, only a small percentage of practices have more than four members. That makes it difficult for busy physicians to compare notes with colleagues about effective practice

management patterns. Yet, as Dr. Yazvac notes, comparative information can be very eye-opening, helping physicians understand and implement specific improvements.

Moving closer to proactive medicine

Because of the large population bases covered by managed-care plans, their statistics are generally meaningful. By contrast, most physicians do not have effective recall or tracking systems in their offices that will allow them to practice population-based medicine – that is, to manage their patients' health care proactively, based on medical and demographic information their offices have about each patient.

Currently, for example, in most Ohio practices, patients are totally responsible for making subsequent appointments for follow-through care. Many people fall through the cracks. This could change, however, with large, central databases that could supplement individual offices' capabilities by tracking patient progress and instituting "tickle" files for follow-up care.

"While clinical care is very important, profiles will also provide sometimes surprising information on staff-patient relations and consumer views about physician access and cooperation," says Dr. Yazvac. "In the future, physicians will more commonly use their own care and service profiles for competitive advantage, both with patient care and responsiveness and, in a practical sense, through their earned reimbursement rates." – Carol Larimer

Take Action

For more information on profiling, Linda Yazvac, MD, is available by calling (614) 848-4942, or e-mail at yazqud@worldnet.att.net. Additional information may be obtained from "Controlling Issues – Physicians of Risk: Profiling," in the AMA Organized Medical Staff Section "Legal Advisor" of www.omo-ossn.org/mem-dole/special/omss/omssadv/legal/lgl0897.htm.

Frontier Group may be underpricing policies

Ratings service A.M. Best Co., Inc. reports that Frontier Insurance Group, Inc. will take a \$2.18-a-share loss for the quarter as a result of a \$150 million charge.

According to an article in the service's *Best Week* newsletter (Dec. 21, 1998), this isn't the first time Frontier has taken charges on its medical malpractice business, a sign, analysts say, that the company continues to underprice its policies.

"This is the largest charge Frontier has ever taken – larger than the other charges combined," says Sabra Brinkmann, an equity analyst with Advest Inc. in the *Best Week* article. "Management has taken its eye off the ball. It's indicative of management not adequately pricing policies."

In the ratings report, featured in the January issue of *Ohio Medicine*, Frontier had ratings of A- from Best; A+ from Standard and Poor; and C+ from Weiss.

OSMA Insurance Agency's John Mayer says this is why ratings shouldn't be the only source doctors use in determining the safety of their professional liability company. Factors change constantly, he says. "That's why you need to monitor the ratings service Web sites. You can't depend on the ratings themselves to give you an accurate picture of how well your company is doing."

In addition to publishing quarterly reports of the ratings received by Ohio's largest malpractice carriers in *Ohio Medicine*, the OSMA also provides a link to the Web sites of each of the three ratings services through its Web site, www.osma.org. It is recommended that you monitor these sites often. ■

New booklet explains CLIA regulations

The OSMA Department of Ombudsman Services has prepared a booklet on the Clinical Laboratory Improvement Amendment (CLIA) requirements for physicians with clinical laboratories in their practice. The new booklet tells who must register in the CLIA program, who may apply for a Certificate of Waiver, and which tests are granted status under CLIA's Modifier QW. The booklet is available to OSMA members only, and is free upon request. To order, contact the Department of Ombudsman Services, (800) 766-6762, Ext. 6759. ■

Ohio Medicine

A Publication of the Ohio State Medical Association

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Ohio Medicine (ISSN 0892-2454/USPS 405-200) is published monthly for \$40 a year by the Ohio State Medical Association, 3401 Mill Run Drive, Hilliard, Ohio 43026. Periodicals postage paid at Hilliard, Ohio and at additional mailing offices. POSTMASTER: Please send address changes to Ohio Medicine, 3401 Mill Run Drive, Hilliard, Ohio 43026.

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Colleagues

Portrait

Bob Donovan, MD, administers to Cincinnati's homeless from Mobile Health Care Van

After four and a half years in private practice, Bob Donovan, MD, felt called to do something for people with little or no choice in terms of medical care. His religious background as a Marianist Brother and part-time work at a neighborhood health center in Cleveland lead to practicing medicine full time with the Mobile Health Care Van in Cincinnati.

Aboard this 40-foot truck, complete with two examining rooms and a lab, Dr. Donovan administers to the poor and homeless. With the help of two medical assistants and a case worker, they conduct common tests – blood sugar, urine analysis, pregnancy tests – and treat conditions common among the homeless, like foot blisters. "We do as much as we can and refer cases we can't treat to the University Hospital," says Dr. Donovan of their range of services.

In the Cincinnati area, homelessness numbers 1,800 per night, and up to 18,000 per year. One third of the homeless population has an alcohol or drug-related problem and one quarter suffers from mental illness. Forty percent of homeless adults are military veterans, who suffer from drug and alcohol abuse and post traumatic stress disorder. Local shelters have programs to deal with alcohol and drug problems, yet mental illness is different. Which came first, the mental illness or the homelessness? "It's a chick and egg issue," claims Dr. Donovan. "Either way, they fall through the cracks, as the mental health-care system is inadequate for people without insurance."

Seventeen percent of homeless people are employed full time, yet have no medical insurance, a fact that Dr. Dono-

vian laments. "It doesn't make financial sense for millions of people to be without medical insurance," he says.

With the AIDS epidemic, the Mobile Health Care Van regularly distributes condoms. "We're big on disease prevention," states Dr. Donovan. "Statistics across the country indicate that HIV is more common among the homeless," he adds, stressing a need for prevention and education.

Living as well as working in this poor neighborhood has been a great teacher. "Living as simply as possible, as these people must, helps me understand them and their situations," reflects Dr. Donovan who lives with a group of brothers from his Catholic religious order. "The more you do the more you see the similarities, not the differences between these and other people – people are the same, it's just our perceptions that differ."

Dr. Donovan views his work with the underprivileged as a means of sharing his gift of medicine and as a way to give back to the community. In talking about homelessness, and the spirituality of homelessness and life in the inner city, he tries to encourage other doctors and medical students to follow a similar path of medicine, even if it means volunteering only a few days a month.

- Pamela J. Willits

Send us your colleagues

If you know of an OSMA member who has recently received an award, or been recognized for outstanding achievement, please send that information along with a photo to:

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Obituaries

CHARLES L. JOHNSON, MD, Cincinnati, University of Cincinnati College of Medicine, Cincinnati, 1965; age 59; died Dec. 15, 1998.

F. W. KUBBS, MD, Mt. Gilead, Ohio State University College of Medicine, Columbus, Ohio, 1946; age 78; died Nov. 26, 1998.

HERBERT G. MAGENHEIM, MD, Cincinnati, Jefferson Medical College of Thomas Jefferson University, Philadelphia, 1959; age 66; died Nov. 29, 1998.

PAUL MESAROS, MD, Steubenville, Case Western Reserve University School of Medicine, Cleveland, 1943; age 81; died Dec. 17, 1998.



Brett M. Coldiron,
MD

JOSEPH L. MODIC, MD, Cleveland, Case Western Reserve University School of Medicine, Cleveland, 1940; age 83; died Dec. 9, 1998.

PETER H. MULDER, MD, Lakeside, Ohio State University College of Medicine, Columbus, Ohio, 1942; age 82; died Dec. 4, 1998.

ROBERT W. PARRY, MD, Youngstown, University of Nebraska College of Medicine, Omaha, Neb.; 1950; age 78; died Nov. 8, 1998.

CORWIN A. SMITH, MD, Dayton, University of Cincinnati College of Medicine, Cincinnati; 1932; age 93; died Dec. 20, 1998.

JUDD W. UHL, MD, Hamilton, University of Cincinnati College of Medicine, Cincinnati; 1941; age 82; died Nov. 1998.

THOMAS TODD, MD, Cincinnati, received the Ohio Family Physicians Foundation first ever Philanthropist of the Year Award. ■

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Ohio Medicine

A Publication of the Ohio State Medical Association

3

rompt payments by insurance companies are rare, say OSMA members – despite the state's prompt pay law. The OSMA is responding to your concerns by seeking a stronger, more enforceable law.

4

Residents and clinical fellows will need to obtain a training certificate by summer, due to a new law that was developed with the help of the State Medical Board of Ohio.

1

Bob Taft, Ohio's new governor, explains his proposed managed-care reforms, as well as his plans for spending his Tabacco Settlement fund, in Ohio Medicine.



11

OSMA identifies and addresses member concerns through its new Statewide Advocacy team, a new program that could travel to your area soon.



Don't forget April 13 is the deadline to make your hotel reservations for the OSMA 1999 Annual Meeting in Cincinnati.

Cleveland charter revoked

The Academy of Medicine of Cleveland violated a mediation agreement reached in December, as well as OSMA bylaws on unified membership.

The Academy of Medicine of Cleveland (AMC) is no longer a component society of the OSMA. The OSMA Council revoked AMC's charter for the second time in less than two months because AMC failed to adhere to OSMA bylaws and the bylaws of its chartered county medical societies.

The first revocation in November was rescinded after a formal mediation between the two groups attempted to resolve long-standing disputes over unified membership and solicitation. The second revocation is the result of the AMC's violation of the mediation agreement, as well as OSMA constitution and bylaws. The OSMA Council voted to revoke the charter and sever all ties with AMC on Jan. 23.

Unified membership in dispute

Since 1846, the OSMA bylaws and the bylaws of its chartered county societies, including those of the AMC, has required unified membership. Under this arrangement, no member can be accepted into either body without joining the other group. For several years, the AMC has tried to convince the council and House of Delegates to overturn the unified membership requirement, but the OSMA House of Delegates, the association's governing body, voted down de-unification twice, most recently in May 1998.

The council did everything possible to avoid the estrangement. By violating both its OSMA-issued charter and the terms of the mediation agreement,

AMC left the association with no option but to follow the unification policy reaffirmed as late as last year by the House.

New society formed

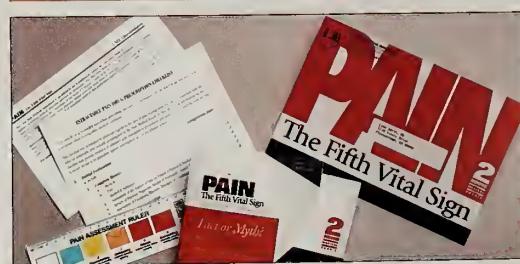
At this point, the OSMA's primary concern is the continuation of association benefits and services to the physicians of Cuyahoga County. Effective immediately, any Cuyahoga County physician who has already paid 1999 membership dues to join AMC and OSMA will be automatically made a member of the new Cuyahoga County Medical Society (CCMS). Physicians who wish to retain their link to the OSMA and who have not yet paid

1999 dues should have received, by now, a dues billing for CCMS and OSMA. The CCMS dues are \$5 a year.

Future activities of the CCMS will be determined by its membership, and the OSMA over the next several months. Initially, the organization will provide physicians the ability to join or remain members of the OSMA. ■

Take Action

If you are a Cleveland-area physician, and have questions about your membership, you may contact the CCMS at (216) 861-0633 or the OSMA at (800) 766-6762.



Don't miss out on this CME opportunity. By now, you should have received *Pain: The Fifth Vital Sign*. It is vital that you take the CME test and return it to the OSMA and help fight future efforts to mandate topic-specific CME. If you have not received the handbook contact Robin Parker, (800) 766-6762.



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Bills, Laws & Rules



Prompt pay problems trigger OSMA legislation

Managed-care accountability leads legislative agenda

The following health-care bills have been introduced in the Ohio General Assembly. If you have questions or would like more information on any of the items listed below, contact the OSMA Department of Legislation, (800) 766-6762. The appropriate staff member and extension number is listed with each bill.

Senate Bills

SB 5 – Health Plans

This bill requires health-care plans to: establish complaint procedures that are consistent with listed requirements and provides rule-making authority to the director of health for the implementation of these complaint procedures; notify enrollees prior to terminating or limiting covered health-care services; to name a licensed physician as the corporation's medical director. SB 5 also establishes the office of the Managed-Care Patient Advocate in the Department of Health to act on patient complaints against health-care plans, and allows female enrollees to designate an obstetrician or gynecologist as a primary care provider.

Sponsor: Sen. Grace Drake (R-Solon)
OSMA contact: Tim Maglione, Ext. 6746

OSMA position: Support with technical assistance.

SB 16 – Physician Practices

If SB 16 passes, any physician who leaves a group medical practice, established on or after the law's effective date, cannot be prohibited from contacting and continuing to provide health-care services to those individuals who were the physician's patient while in the practice. A similar bill was introduced last session.

Sponsor: Sen. Robert Gardner (R-Madison)

OSMA contact: Krista Bistline, Ext. 6748

OSMA Position: Under advisement

SB 17 – Newborn Screening

SB 17 revises the law regarding rules that require the screening of newborn children for genetic, endocrine and metabolic disorders. A similar bill was introduced last session.

Sponsor: Sen. Grace Drake (R-Solon)

OSMA contact: Marla Bump, Ext. 6741

OSMA Position: Support with technical assistance

SB 19 – Nursing Practice

The nurses have re-introduced their patient safety bill that includes, among other things, an increase in the penalties assessed for the unauthorized practice of nursing. It also requires the Ohio Department of Health (ODH) to maintain a toll-free number for accepting complaints regarding patient safety, and it also requires health-care providers to report to ODH certain data about patient outcomes and the use of nurses.

Sponsor: Sen. Grace Drake (R-Solon)

OSMA contact: Marla Bump, Ext. 6741

OSMA Position: Under advisement

SB 28 – Patient Advocate Office

This bill establishes the Office of Patient Advocate in the Department of Health. It also makes changes in the Health Insuring Corporation (HIC) Law, in relation to the liability and operation of HICs, as well as enrollees' rights; requires the offering of more coverage options in the group marketplace; and increases the information

provided in a subscriber's evidence of coverage.

Sponsor: Sen. Robert Hagan (D-Youngstown)

OSMA contact: Nick Lashutka, Ext. 6747

OSMA Position: Support with technical assistance

SCR 3 – Medicare Reimbursement

This resolution urges the Health Care Financing Administration to withdraw its proposed rules concerning Medicare reimbursement for providing corneal tissue for transplantation, and urges Congress to oppose the rules.

Sponsor: Sen. Grace Drake (R-Solon)

OSMA contact: Nick Lashutka, Ext. 6747

OSMA Position: Active support

House Bills

HB 4 – Health Insurer Liability

HB 4 holds a health insuring corporation (HIC) responsible for harm to an enrollee, caused by the HIC's failure to exercise ordinary care in making a health-care coverage decision. In addition, the bill: provides for speedy review of enrollee appeals of adverse determinations; allows female enrollees to obtain health-care services from a participating obstetrician or gynecologist without a referral; requires HICs to name a licensed physician to act as a corporation's medical director; requires that at least one telephone number be provided to enrollees for health-care plan information, via a toll-free number; and makes additional information available to enrollees; and permits personal income tax deductions for certain medical expenses and long-term care insurance premiums.

Contracts set time lines

At fault in some instances are provider contracts that can either stipulate a different payment schedule, superseding the law, or which state, ambiguously, that the third party will make a "good faith effort" to pay the doctor on a timely basis. In its current draft, the proposed law would establish a "contractual exception" to third-party contracts that says claims must be paid within 30 days for paper claims, 15 days for electronic claims. Those time frames would override any payment language in third-party contracts. If third parties failed to meet those deadlines, an interest rate of 1.5% per month would accrue and be paid to providers, and a fine, equal to \$500 per day of violation per claim (with a maximum fine of \$5,000 per claim) would be charged the insurer. (These provisions may change, of course, as the bill works its way through the Legislature.)

Bistline says that while other providers have indicated their support for the measure, it faces stiff opposition from insurers and HMOs as well as other groups.

"The Ohio Department of In-

continued on page 6

Residents, clinical fellows will need training certificates by summer

Residents and clinical fellows will now be subject to background checks.

When House Bill 606 became law last year, one of its provisions will have a dramatic impact on resident physicians when it becomes effective in mid-March. The law now requires that residents and clinical fellows (implied by the law) obtain a training certificate before beginning their training programs. Such registration has been optional in the past.

What will this mean to new residents?

Residents will now be required to answer questions about their backgrounds, which was not required prior to HB 606. This will enable staff members of the State Medical Board of Ohio to perform background checks on

Medical Board Report

applicants. If a resident trained in more than one location, or holds an ECFMG certificate, backgrounds likely will be checked.

- The same grounds the board uses to deny a full license to a physician will now be applicable to the training certificate as well.

- If a resident wishes to moonlight, the training certificate will not be enough. He or she will still need a full license.

The board is looking at July 1, when many training programs kick off, as the target date for implementing the

change. Since the law becomes effective later this month, that is when application forms for the certificate will probably be mailed.

Of note...

Exception made for completing licensure exam...Deans of Ohio's medical schools have asked the board for a limited exception to what's known as the "seven-year rule," which states that the licensing examination must be passed within seven years of a doctor's initiating the examination process. The National Board of Medical Examiners has noted there are MD/PhD students who are going beyond the seven years to complete the exam, and the Ohio medical school deans asked for a limited exception for MD/PhD students who are completing a doctorate in a medically-related field, as well as for those with significant health problems. The board noted that the Federation of State Medical Boards is in the process of addressing this problem, but, until the Federation arrives at a solution, the board will allow a total of 10 years from the date of first taking the USMLE to complete the examination sequence.

"Prohibited procedure" list for PAs to be compiled...The board and its Physician Assistants Committee, losing patience with requests to approve procedures and practices that it feels are the practice of medicine, have discussed drafting rules that will list procedures the board believes should be prohibited from physician assistant utilization plans. The PA committee will use a panel of experts to help draft the proposed rules. Committee members told the full board that middle ground on these issues can't be reached, and it's time for the board to put its position on paper. (For information you should know before hiring a PA, see "Your Practice Guide," page 20.)

Laser use discussed...The Minimal Standards of Care Committee contin-

ues to gain information on the use of lasers, and hopes to draft a rule on the subject. The committee's concern is that some physicians delegate the use of lasers to unlicensed individuals, and, while there is currently no Ohio law that addresses the use of lasers, the committee believes the board needs to place something in rules that states specifically who may and may not use these modalities. In addition, the committee questions whether or not cosmetic therapists should be allowed to use lasers for removing hair and spider veins.

Internet prescribing reaches Ohio... The state pharmacy board contacted members of the board's prescribing committee to inform them that Internet prescribing is now available in Ohio, including prescriptions for Meridia and Phen/Fen, anti-herpetic, and a number of "social" drugs. The medical board indicated that Internet prescribing is below minimal standards of care with regard to patient safety, and it would cooperate with the pharmacy board's investigation on this subject. ■

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Medical board elects officers

The State Medical Board of Ohio has announced its new officers for 1999:

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Health-care bills...

continued from page 3

Sponsor: Rep. Randall Gardner (R-Bowling Green)

Status: Health Committee

OSMA contact: Tim Maglione, Ext. 6746

OSMA Position: Active support

HB 16 – Health Care Study

This bill creates a task force to study consumer access to preferred provider plans, point-of-service plans, and other open-panel plans for health-care coverage.

Sponsor: Rep. J. Donald Mottey (R-West Carrollton)

Status: Health Committee

OSMA contact: Nick Lashutka, Ext. 6747

OSMA Position: Support

HB 33 – Insurance Tax Deduction

If passed, HB 33 would create a state income tax deduction for long-term care insurance premiums.

Language in this bill is similar to that stated in House Bill 4.

Sponsor: Rep. Greg Jolivette (R-Hamilton)

Status: Ways and Means Committee

OSMA contact: Nick Lashutka, Ext. 6747

OSMA Position: Support

HB 42 – Birth Control Coverage

HB 42 requires certain sickness and accident insurance policies, public employee benefit plans, and health-insuring corporation policies, contracts and agreements to provide coverage for contraceptive devices and drugs requiring a physician's prescription.

Sponsor: Rep. William Schuck (R-Columbus)

Status: Insurance Committee

OSMA contact: Nick Lashutka, Ext. 6747

OSMA Position: Support

HB 52 – Health Insurer Liability

This bill holds a health-insuring corporation (HIC) responsible for harm to an enrollee caused by the HIC's failure to exercise ordinary care in making a health-care coverage decision or by the HIC's delay in reaching a decision. It also requires the Department of Insurance to annually prepare a brochure that enables the public to

evaluate and make a meaningful comparison of health-care plans or HICs; makes additional information available to enrollees; makes changes to the HIC law, with regard to utilization review and enrollee appeals; allows female enrollees to obtain health-care services from a particular obstetrician or gynecologist without a referral; and requires HICs to name a licensed physician to act as a corporation's medical director.

Sponsor: Rep. Jeff Jacobson (R-Dayton)

Status: Civil and Commercial Law Committee

OSMA contact: Tim Maglione, Ext. 6746

OSMA Position: Support with technical assistance

HB 53 – Mental Health Coverage

If passed, HB 53 would prohibit discrimination in health-care policies, contracts and agreements in the coverage provided for the diagnosis, care and treatment of mental illness and substance abuse or addiction. This bill is similar to the mental health parity

bill introduced last year, but HB 53 has a broader scope.

Sponsor: Rep. Lynn Olman (R-Maumee)

Status: Insurance Committee

OSMA contact: Nick Lashutka, Ext. 6747

OSMA Position: Active support

HB 71 – Patient Behavior

HB 71 addresses what actions may be necessary for mental health professionals and organizations to predict, warn of, or take precautions to prevent the violent behavior of mental health clients or patients. The bill is similar to last session's "duty to warn" bill.

Sponsor: Rep. Rose Vespa (R-New Richmond)

Status: Health Committee

OSMA contact: Marla Bump, Ext. 6741

OSMA Position: Active support

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One-on-one with Ohio's new governor

Gov. Bob Taft talks to physicians about his managed-care reform initiative and other health-care issues that will be important this legislative session.

Q: During the campaign, you proposed a number of managed-care reforms, including income tax deductions for health care and insurance, and reinstatement of fast-tracking insurance appeals within managed care. Now that you're governor, tell us about your strategy for moving forward on these issues.

A: The Patient Protection Plan (House Bill 4), currently under consideration in the Legislature, proposed by my administration, and introduced by Rep. Randy Gardner, is a significant step toward increasing access to high-quality affordable health care for Ohioans. The plan requires health insurance companies' medical directors to be licensed physicians, provides for timely review of enrollee appeals, and expands direct patient access to essential services. In addition, the Patient Protection Plan also grants three new income tax deductions for those Ohioans who have extraordinary medical expenses, the purchase of long-term care insurance, and health insurance expenses incurred by more than 400,000 working Ohioans whose employers do not provide health coverage. I look forward to working with the General Assembly to secure passage of these initiatives and taking this important step to improve the quality of health care for Ohio's families.

Q: A number of other health-care policy issues are on the horizon. What are your thoughts on the following issues:

A: Children's Health-Care Initiative Program (CHIP)? I have been and remain a proponent of expanding eligibility for the CHIP program from 150% to 200% of the federal poverty level. This is an important step to ensure that children in more than 40,000 families, including many who have moved from welfare to work, receive the health care they need during the all-important early stages of life. I will work with the Legislature to ensure that CHIP eligibility is expanded this year.

A: Plans for spending Ohio's share of the Tobacco Settlement funds? I applaud the hard work of Attorney General Betty Montgomery and the other state attorneys general to achieve this comprehensive settlement



New governor outlines health-care plans. Gov. Bob Taft, shown here at his inauguration with his wife, Hope, and daughter, Anna, wants medical directors of insurance companies to be licensed physicians. (Photo by Jack Kustron)

with the tobacco companies. Although we have only begun to consider the disposition of Tobacco Settlement money, a great deal depends on whether the federal government will attempt to recoup some of the money. We will not be able to formulate a final plan for spending the money until such decisions are reached. However, I believe that, whatever the outcome, we must be sure that public health concerns – including tobacco and substance abuse cessation programs – receive their fair share of the money. I also believe that our school facilities needs should be considered as we begin to think about how the funds should be spent. Finally, I support Ohio Sen. George Voinovich's effort to pass federal legislation to prohibit the federal government from taking states' tobacco settlement funds.

A: Other health-care issues you are thinking about? In addition to the health care and health insurance-focused goals embodied in HB 4, I believe we must consider how we can reduce tobacco use among our youth. Limiting youth access to tobacco will require a cooperative process that includes state government and representatives of the medical, health care, and business communities to find a solution that is both effective and fair. This will be a significant achievement, and one that will reflect the concerns we all share for the health and welfare of our children. ■

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Prompt pay...

continued from page 3

surance (ODI) says it isn't convinced there is a problem with prompt payment of claims," says Bistline. The department is charged with enforcing the current prompt pay law, but it says its records show only 700 complaints regarding prompt payment.

"We don't think that's indicative of whether or not there is a problem," says Bistline. Doctors may not know to call ODI with prompt pay problems, and some may be too discouraged by ODI's lack of enforcement activity on this problem to date to make a call.

Consequently, the OSMA has conducted a survey of 2,300 randomly-selected physicians, as well as 900 group practice administrators to gather information on the promptness of payments. This information, Bistline says, is likely to provide the ODI, the insurance community as well as legislators with the proof needed to illustrate the extent of the problem within the medical community.

"The AMA has provided us with a legislative template, and we're moving forward on having this legislation introduced in the Ohio General Assembly as soon as possible." ■

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Malpractice clarification

The information that appeared in the February issue of *Ohio Medicine* about the amended law now requiring the State Medical Board of Ohio to investigate cases of repeated malpractice has created some confusion, according to *Ohio Medicine* readers. The law defines "repeated malpractice" as:

"Three or more claims for medical malpractice within the previous five-year period, each resulting in a judgment or settlement in excess of \$25,000 in favor of the claimant, and each involving negligent conduct by the physician." *Ohio Medicine* regrets any confusion created by its previous report. ■



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OSMA News



OSMA's new StAT team will hit the road to address your concerns

Association staff members will customize up-to-date information on health-care issues important to you, and tell you how organized medicine is responding to these concerns.

Each year, the OSMA monitors the most pressing issues facing Ohio's physicians and forms a proactive response, whether that's in the form of legislation, new policy, letters, lawsuits, even a quick call to third parties. Yet, a recurring problem that has surfaced in written surveys and focus groups conducted by the OSMA is that members are not always aware of: 1.) Ohio health-care's most pressing issues; and/or 2.) OSMA's response to those subjects.

Personal presentation is key

Despite attempts to communicate with members through printed messages (like *Ohio Medicine*), electronic communications, and visits to county society and hospital staff meetings, the OSMA's message is not received by all of those it hopes to reach.

"What we have learned," says Doug Evans, director of Membership Services, "is that, on average, members respond much better to a personal presentation of issues, benefits, and what the OSMA is doing." The OSMA has, at present, only one staff member who makes these kind of personal presentations — Northeast Ohio field representative Ben Reynolds. "There was a big difference in members' knowledge about the OSMA when we compared the northeast members to the rest of the state," says Evans. That's what convinced the OSMA, it was time to take its message directly to members where they live and work.

Enter StAT, the acronym for Statewide Advocacy Team. Its mission is to raise your awareness about the value of organized medicine — not just at the state level, but on the county and national (AMA) level as well. StAT will be a road show, traveling to your area, addressing your unique concerns. Its target audience — group practices, hospital staffs, specialty societies, ethnic physician organizations, county medical societies, and academic groups — will hear, firsthand, news about the issues that directly impact them.

Programs to be tailored

"Before we visit, we'll ask, 'What are your most immediate concerns?'" says Evans, "then we will tailor our presentation to meet those needs." StAT will also relate how OSMA and organized medicine is responding to the problems.

In addition, those attending a StAT presentation will receive:

- a review of OSMA benefits and services;
- information about tangible member services, such as: legislative and regulatory advocacy, ombudsman and professional services, continuing medical education, practice management and legal services;
- a rundown on how members can become involved on issues and how nonmembers can join;
- information about county society and AMA activities and benefits.



StAT team in action. Members of the OSMA StAT team will tailor presentations to targeted audiences. From left, Lucy Kitner, Jennifer Hyle, and Nick Lashutko.

The immediacy of the information may be the most appealing feature of this type of communication. All legislative and regulatory news, for example, will be up to date, and if a physician wishes to join the ranks of organized medicine, he or she can be accommodated on the spot with applications and membership material.

StAT will be comprised of several teams of three to four OSMA staff members, representing membership, public affairs, legislation, ombudsman services, legal and support personnel. Presentations, in addition to discussions with physicians, will include a 10-15 minute multimedia presentation; tabletop displays; and coordinated print materials.

"The program will be ready for presentation by April 1," says Evans. ■

Take Action

If you would like StAT to come to your area, contact Lucy Kitner, Division of Membership Services, (800) 766-6762, Ext. 6776.

Domestic violence kicks off initiative

The OSMA, in cooperation with interested county medical societies, will launch a major educational initiative this year on the subject of Women's Health. Educational efforts are expected to continue into the year 2000.

"Women's Health has become an increasingly important subject," says Lance Talmage, MD, OSMA president, who prompted two of the projects — on domestic violence and osteoporosis. New research and updates in these areas, as well as in breast cancer, cardiology and cervical cancer allows the OSMA's Education Committee to update Ohio physicians all of these topics.

The initiative will begin this spring with a new handbook on domestic violence. The handbook will be similar to the one the OSMA produced several years ago, as part of its Family Violence campaign. The revised version, however, will feature an updated list of shelters and other resources, new legal information, and the AMA's clinical guidelines on domestic violence.

Later, the association will produce an educational handbook on osteoporosis for physicians, as well as a public education campaign that will encourage screening and other preventive measures for women who are at risk.

Then, this fall, the OSMA, working with the Ohio Department of Health, will provide physicians with the latest information on breast cancer screening, and communicating results to patients. For the first time, this material will be available on the Web, through the OSMA's Web site, as well as in hard copy.

Cardiology and cervical cancer are subjects of initiatives that will be presented in 2000. Watch *Ohio Medicine* for further details.

AMA Update

AMA's advocacy role is wide-ranging

From reimbursement matters to legislative and legal issues, the AMA works on behalf of medicine in both large - and small ways.

By Andrew Thomas, MD

As we look toward the 1999 Congressional session, medicine has a full plate of issues to contend with in Washington. From managed-care reform to antitrust relief to our attempts to refocus the fraud and abuse debate, there is a lot of work to be done.

In this month's AMA Update, however, I want to revisit some of the successes that organized medicine has had



Andrew Thomas, MD

over the last year. You should already be familiar with many issues that made it to the headlines - increased funding for the National Institute of Health, success in modifying HCFA's E&M Documentation Guidelines, and a nearly-passed Patient Bill of Rights. But, the items I want to tell you about are probably not well known to you - they are what we call the "Little Things that Add-up."

• **HCFA Behavioral Offset** - On a yearly basis, HCFA scales back physician payments based on the theory that physicians increase volume to make up for decreases in reimbursement. AMA lobbying convinced HCFA to drastically modify the behavioral offset formula, restoring approximately \$500 million to the Medicare physician payment pool for 1999 alone. This policy change will also affect physician payments year after year.

• **Medicare Provider Fee** - The

AMA successfully lobbied against a proposal in the 1999 Federal Budget for a Medicare Provider Fee of \$100 that was to be imposed on all physicians participating in the Medicare program. This proposal will most likely appear again in the 2000 Budget, and the AMA will again be there to advocate on your behalf.

• **Medicare Explanation of Benefits** - AMA efforts persuaded HCFA to change the wording on Medicare beneficiary statements regarding uncovered physician services. It will be changed from the inflammatory "Not medically necessary" to something like "This service is not covered" or "The information provided does not support the need for this service."

• **Unintentional Billing Errors** - In an effort to allay physicians' fears, the AMA secured a letter from the HHS Inspector General (IG) clarifying that physicians will not be subject to either

civil monetary penalty laws or the False Claims Act for billing errors and honest mistakes. Also, at the prompting of the AMA and AHA, Congress called for a GAO review of the Department of Justice and HHS IG's fraud and abuse enforcement policies. This is part of a continuing process to refocus and restore balance to the government's fraud and abuse activities.

• **Antitrust Relief** - At their July 1998 hearings, members of the House Judiciary Committee (armed with AMA evidence) highlighted inappropriate managed-care contracts and pressed the chair of the Federal Trade Commission about the imbalance of power between physicians and insurers. At those same hearings, the AMA's testimony in strong support of the Campbell Bill was well received and should lead to fruitful progress in the coming session.

• **PATH Audits** - In response to AMA and AAMC lobbying and lawsuits, the HHS General Counsel scaled back and refocused the HHS IG's PATH audit program.

• **Other Highlights** - AMA advocacy saved approximately 100 doctors from repaying \$1 million due to a Medicare carrier error on chemotherapy payments ... Against significant opposition, the AMA generated support for and helped secure the confirmation of David Satcher, MD, to the post of Surgeon General ... The AMA lobbied to preserve and actually increase funding for the Agency for Health Care Policy and Research (AHCPR) against the wishes of its Congressional critics ... JAMA dedicated a special issue to tobacco and the AMA lobbied strongly for increased FDA regulation of tobacco products. ■

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Andrew Thomas, MD, Columbus, serves as the resident representative on the AMA's Board of Trustees.

From the county files...

CMA seeks to boost autopsy rates

Long before the television show "60 Minutes" described the declining number of autopsies performed in this country, the Columbus Medical Association (CMA) was struggling to understand why Franklin County had its own low autopsy rate.

According to Diane May, CMA co-interim executive director, the issue was raised by members of the Central Ohio Trauma System (COTS) Foundation—the group formed by CMA, originally, to develop a local trauma registry. COTS Foundation is chaired by Columbus trauma surgeon Robert Falcone, MD, and is composed of CMA members, as well as representatives from each of the area's hospitals, Franklin County Commissioners' Office, Franklin County Fire Chief's Association, Columbus Health Department, and EMS entities. Dr. Falcone noted at a COTS Foundation meeting back in 1997 that other metropolitan areas in Ohio have a higher autopsy rate on trauma patients than Franklin County, and that, without the data autopsies provide, improved trauma treatments and prevention efforts would be slow in coming.

Improving relations with coroner

"Since then, we have been trying to develop a better relationship—and communications—with the Franklin County Coroner's office," says May.

The COTS Foundation Autopsy Policies Committee recommended that a form be developed that could be faxed to the coroner's office on the day of death of a trauma patient. As a result, the COTS Foundation has created a form, and May says it will be implemented probably within the next few months. The form includes: 1.) request for an autopsy; 2.) consent, signed by the patient's family; and 3.) a request for an autopsy report. Autopsy data will be compiled in the COTS Foundation Registry, and will be reviewed by the Oversight Committee.

IMG Task Force aims to boost participation

Each new physician brings a unique perspective to his or her practice. For international medical graduates (IMGs), that personal "stamp" on the profession—a reflection of diverse cultural and social backgrounds—often is perceived as a deterrent to acceptance, says Andres B. Lao, MD, chair of the OSMA International Medical Graduates Task Force.

He is hoping the IMG Task Force can help dispel some of the misinformation, misperceptions and resultant disbelief and mistrust that serve to deter IMGs' involvement in organized medicine. One step toward that goal is the second annual IMG seminar scheduled for April 17 in Cleveland. (See related story for details.)

"All of us (physicians) should be able to access the leadership of organized medicine for common problems, like managed care," Dr. Lao says. Raising and addressing general issues

that affect all physicians is easier than dealing with IMGs-related concerns. Dr. Lao says he hopes the OSMA's task force can provide a comfort zone where IMGs can raise and discuss their specific concerns. He also hopes the task force helps pave the way for greater involvement in OSMA by physicians from other countries.

It is important to respond to the IMGs' concerns from their unique perspective. "You have to explain it in their terms," Dr. Lao says. That is why ethnic professional associations are so important; they offer a forum where the physicians can discuss and come to understand medical practice here. The more that they can work through their mutual concerns, the more they can bring to the American cultural melting pot—and the OSMA. —Anna Rzewnicki

Patient education brochure

But a working relationship between hospitals and the coroner's office is only part of the picture. Perhaps the largest piece is patient education.

May reports that CMA and the COTS Foundation have developed a patient education brochure that explains the importance of autopsies to family members. This brochure will be distributed in coming months to hospitals, libraries, churches and other appropriate locations.

In addition to defining an autopsy, the brochure answers likely questions: Who benefits from an autopsy? Will it alter funeral arrangements? Is there a charge? Are there religious concerns? How can results be obtained?

CMA and the COTS Foundation hope that this two-prong approach—patient education and increased cooperation between the coroner's office and hospitals—will raise Franklin County autopsy rates to a level at least equal to and even surpassing other metro areas in Ohio.

The CMA/COTS Foundation solution is just one example of how organized medicine, at all levels, identifies the issues impacting your practice—and how it responds to your specific needs. ■

Take Action

"From the county files..." is designed to show how county medical societies are identifying and responding to issues in their area with programs and activities that you may wish to borrow for your county. If you would like more information about this particular program, or a copy of the autopsy brochure, contact Diane May, co-interim executive director, Columbus Medical Association, 431 East Broad Street, Columbus, OH 43215, (614) 240-7415 or the Central Ohio Trauma System Foundation at the same address, (614) 240-7419.

Seminar scheduled for IMGs

The OSMA International Medical Graduates' Task Force is presenting its second annual educational program on Saturday, April 17, for international physicians practicing in Ohio. The seminar will be held at the Cleveland Hilton South. Following are seminar details. Pre-registration is required. Contact Doug Evans at (800) 766-6762 for registration information.

Registration: Begins at 8 a.m.

Morning session:

- An overview of state and national IMGs activities.
- Keynote address on coalition building.
- Review of OSMA activities.
- IMGs panel discussion on issues that impact IMGs and their practices.

Afternoon session:

- Managed-care practice management workshop.

Objective association decision-making

It was not long ago I would not have believed anybody who told me that an association could be objective in its deliberations. However, after a conference for elected association leaders and executives last year, I found there are objective criteria for decision-making which apply to the work of your OSMA Council. These knowledge bases and the decision-making process of applying them have been evident in my work with the council over this past year. This is a hard-working, and very conscientious group who have tried to carry out what is appropriate for the membership, as well as innovate new efforts and programs to bring value to the members.

The four essential knowledge bases are: 1.) sensitivity; 2.) foresight about the profession; 3.) insight into the ca-



Lance Tolmoge, MD

President's Perspectives

pacity and strategic position; and 4.) awareness of ethical implications. In each of the council deliberations, these four knowledge bases are called upon and discussed in order to bring us to a decision that we feel is appropriate to the entire membership of the OSMA.

In my long experience on the council, each president has been confronted with an unanticipated and time-consuming issue which has often interfered with the objectives and programs set out for that year. We have had PICO, PIE, Task Force 2000, and now the question of the actions of the Academy of Medicine of Cleveland. In reviewing each of these issues, although in a less structured way in past years,

we have used these objective criteria to come to a decision which we felt would be consistent with and be of value to our membership. As the facilitator for your councilors, I cannot begin to express the degree of admiration that I have for this group elected by you who have served you well. They have sometimes had to accept positions that they are personally not enthusiastic about because it is for the greater good and represents the culture of the majority of our membership. Your trust in them is well placed.

As the OSMA Annual Meeting draws near, resolutions from the membership will guide us in future years and perhaps change our direction if that is the association's desire. Our recent, aggressive stance in joining the suit against ODI and ODHS has resonated well with members. While it is not appropriate for our image to constantly go to court, I think that other issues may well need this back-up strategy in order to have our legislative and regulatory needs met. The new patient protection bill which has been submitted by Sen. Randy Gardner with the backing of the governor is an excellent example of the OSMA addressing the sensitivity of its members and advocating for patients even though there is major opposition that we will have to face. Prompt pay legislation is another essential to the practice of our members and will be pursued.

I urge you to communicate with your district councilor as well as directly with me or the appropriate OSMA staff member. With your input we can maintain the four essential

knowledge bases which we must have to make future decisions as advocates for patients and physicians in Ohio. Our sensitivity to your needs, wants, and preferences and our knowledge of the evolving dynamics of our profession, depend upon your input. I can promise you that we will always analyze our strategic position and make sure that we have considered the ethical implications in our decisions. Those of us in leadership positions realize that the value that you and perspective members place on the OSMA depends upon our ability to add value to your ability to practice good, quality medicine for the patients of Ohio.

I would urge you to come to the Annual Meeting with concerns and just as important, potential solutions. We need to provide education such as the pain program, domestic violence prevention, osteoporosis detection and treatment, and the risks of tanning. Your ideas of future projects will enhance our value as physicians. The ability to provide these and other services to our patients depends on the involvement of all Ohio physicians to put the train back on the tracks. The system is in chaos and activism in organized medicine is the only way to rewrite or reduce the regulations, reroute the money from managed-care CEOs to needed care and renew the pact with our patients to create health instead of treating preventable disease. Support your delegates, councilors, and officers with ideas, activism and encouragement. Remember, we can't accomplish all we try to do, but we accomplish nothing we don't try to do. ■

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OSMA happenings...

Group practice profiles wanted... The OSMA is still collecting information on group practices for its 1999 Group Practice Directory, to be distributed later this year to all participating group practices. In addition to providing a profile of the group practice, survey results will also be used to gauge the needs of group practices so that the OSMA can better serve both group physicians and administrators. If you are in a group practice and have not yet completed a profile, you may obtain the form by contacting Susan Rupli, director, Group Practice Services (800) 766-6762, Ext. 6775, or call the *Ohio Medicine* reader response line, (800) 766-6762, Ext. 6580, and ask for item #5-99.

Make reservations now for Annual Meeting...Delegates and alternates who plan to attend the OSMA Annual Meeting in Cincinnati May 14-16 need to make their hotel reservations by Tuesday, April 13. Officers, councilors, and delegates will stay at the Hyatt Regency, a short, connected walk from the Convention Center where meeting events will take place. To register, delegates and alternates should complete the form they receive in their "Call to Meeting" packet. Those packets will be sent soon. If you do not receive a packet by the end of the month, contact Susan Paulus, Annual Meeting coordinator, (800) 766-6762, Ext. 6727.

Don't forget...If you have not yet submitted your resolution for this year's Annual Meeting, you still have some time left to do so, but it's growing short. The deadline for resolutions is Monday, March 15. Send your resolution by that date to: Brent Mulgrew, Executive Director, OSMA, 3401 Mill Run Dr., Hilliard, OH 43026 or fax to (614) 527-6763, or e-mail: brentm@osma.org. Next month you can look for resolutions on the OSMA Web site, www.osma.org. Look there, also, for any scheduled changes and other Annual Meeting news. ■

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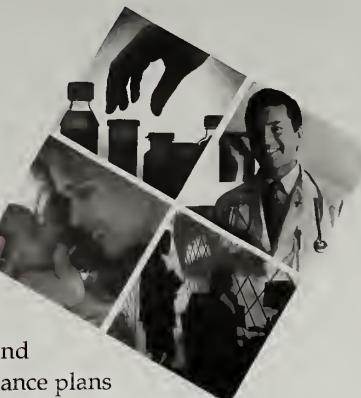
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CME featured opportunities

These two CME programs are among many courses offered by the more than 70 sponsors of CME accredited by the OSMA.

14th Annual Neonatal-Perinatal Medicine Conference

When: March 5

Sponsor: Riverside Methodist Hospitals, Columbus.

Speaker: Five speakers including three pediatric/neonatal physicians, a specialty practice pharmacist and clinical nutritional specialist.

Objective: To review the criteria for high frequency ventilation in neonates, review ventilation strategies, and update current nutritional and pharmaceutical strategies for critically ill neonates.

Time: 8 a.m.-3:30 p.m. at the Grant Medical Center, F.C. Hugenberger Auditorium

For further information contact:
Jana Basham (614) 566-9701

CME credits: 6

9th Biennial Pediatric Symposium: Primary Care Today - An Interactive Conference

When: April 9-10

Sponsor: Children's Hospital Medical Center, Cincinnati

Objective: To update primary care physicians on treatment of various conditions and emergencies seen in the office, including skin diseases, infections, sports injuries and behavioral issues.

Time: 8 a.m.-3:45 p.m. (4/9) and 8 a.m.-3 p.m. (4/10), Westin Hotel, 5th at Race Street, Cincinnati

For further information contact:
Mary Jane Bullen (513) 636-6732

CME credits: Maximum of 11

Practice Tips



Videotaping of childbirth raises some concerns

While video cameras may document potential liability in the delivery room, most doctors say the nuisance factor is a greater problem.

Should videotaped recordings of childbirth be a routine addition to the family archives?

This question – and even a bit of research on the topic – has been popping up across the country in the past year or so. While trying to accommodate parental wishes to gather keepsakes, some hospitals and physicians also recognize the potential for distraction in the delivery room, as well as liability should something go wrong.

"The development of inexpensive, portable video cameras has led to a marked increase in the number of people who want to capture this once-in-a-lifetime event," says Jerome Yankowitz, MD, associate professor of obstetrics and gynecology at the University of Iowa College of Medicine. He supervised a medical student's research on the topic – a topic chosen because it incorporated the breadth of the student's academic background, including business, law, and medicine. Results of the study were published in the March 1998 issue of the *Journal of Family Practice*.

They learned that while some of the doctors interviewed were concerned about possible liability issues that might stem from videotaped births, the majority was not. And most cases that were discussed, Dr. Yankowitz said, were reported secondhand – situations the interviewees had learned of from others.

Video cameras have been used for years to record surgical and other medical procedures, primarily for educa-

"I think the correct point of view is that the people in the delivery room should be there primarily and foremost to assist the mother and baby in the birth process," – J. Craig Strafford, MD



tional purposes, says Mary Yost, spokesperson for OHA: The Association of Hospitals and Health Systems. Hospitals established guidelines regarding such recordings, including patient consent and whether the videotape would remain part of the patient's medical record.

Concern about family recordings for private use hasn't risen to a level requiring a policy statement from the association, she said. "This is ... the sort of thing that we would leave up to the hospital to develop its own policies, and a lot of times I think that will be driven by the physicians doing the deliveries," she added.

J. Craig Strafford, MD, chair of the Ohio section of the American College of Obstetrics and Gynecologists, said, "there is a liberal and a conservative point of view on this." He embraces the conservative view.

"I think the correct point of view is that the people in the delivery room should be there primarily and foremost to assist the mother and baby in the birth process," he said. Being busy with a video recorder can detract from the attention and assistance a support person could be giving the mother. The videotaping process can also get in the way, Dr. Strafford said, noting that he has heard of personnel being asked to move for the sake of the camera.

"From a providers' perspective, there also is some slight anxiety about having this used against you if the ba-

by isn't perfect," he added. He considers liability issues, however, to be only 10% of the matter.

Kathi Burton, risk manager with Mutual Assurance of West Virginia, which also serves Ohio, noted that while the process can encourage family involvement and welcome, videotaping also can cause unwarranted concerns if the mother or other family members see something happening that they don't understand. "Sometimes they take the video to another practitioner for a second opinion."

"From what I understand, a lot of hospitals have developed policies and procedures regarding (this) – whether they would allow it and under what considerations or circumstances," she said.

Even a policy banning video cameras might not deter some parents. The *Dallas Morning News* last year reported a story of a couple that surreptitiously taped their daughter's birth after learning video cameras were banned from the delivery room.

On the other hand, having permission doesn't mean the camera will be on when the action begins. Dr. Yankowitz said he has heard several fathers exclaim that they'd forgotten to bring the camera to the delivery room – or forgot to turn it on. – Anna Rzewnicki

Establish guidelines for video cameras

Bringing a video camera into a delivery room – a particularly intimate environment – needs to be done with a comfort level acceptable to all parties involved.

Sources for this article offered the following points for consideration when setting guidelines.

- Recognize that in today's environment, more and more parents may want to videotape their child's birth. Be prepared to discuss it.
- Develop and maintain good communications between you, your patient and support person(s).
- Know and follow your hospital's policy.
- Have the patient sign a consent form. It doesn't mean the patient is giving up the right to sue, but it will clarify what is allowed in the delivery room and the procedures.
- Be aware that sometimes things can go wrong and the videotape might be used in court.
- Acknowledge that some people, including health-care professionals, are uncomfortable in front of a camera. If the camera would be a distraction and get in the way of quality health care, consider disallowing it.
- Communicate that under certain conditions the camera may need to be turned off, clarify those conditions. – Anna Rzewnicki

Colleague explains new pain rules

You have the new pain rules, but can you put them into practice? The editor of the OSMA handbook, *Pain – The Fifth Vital Sign*, makes the rules easier to understand.

By Robert Gillette, MD

In mid-October, the State Medical Board of Ohio adopted a new set of rules for the use of controlled analgesic drugs in the treatment of patients with intractable pain. The new rules are couched in legal terminology that makes heavy reading for physicians – which is why this writer has prepared the following summary of their content. This article has not been reviewed by the medical board, or any other authority. It represents its author's understanding of the rules and their application to medical practice. Readers should contact the board, or their own legal counsel, in any situa-

tion where a definitive interpretation is required.

Defining intractable pain... The rules define "intractable pain" as that having "a cause for which no treatment or cure is possible, or for which none has been found. The definition specifically excludes conditions that can be expected to "result in a terminal condition" so you can prescribe opioids for your patients with AIDS or disseminated cancer without fear of running afoul of the new rules, provided only that you keep complete records of your findings and prescriptions and follow established medical practice otherwise. "Protracted" treatment is defined as that of more than 12 weeks duration.

Documenting treatment... Before starting protracted opioid treatment for chronic nonmalignant pain, you must document the following in the patient's record:

- An initial evaluation including history of the present illness, alcohol

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What the rules require:

The new pain rules, developed by the State Medical Board of Ohio, require that you:

- Document treatment in the patient's record.
- Secure independent support for your diagnosis and treatment plan.
- Obtain informed consent from your patient.
- Provide follow-up care.
- Order drug screens if necessary.
- Refrain from self-prescribing, and prescribe for a family member only in an emergency.

or substance abuse, impact of the pain on the patient's physical and psychological functioning, previous diagnostic studies and treatment, coexisting health problems and an appropriate physical examination:

- A medical diagnosis with an indication of how it was developed; and
- An individualized treatment plan including both drug therapy and other treatments, as well as a plan for periodic evaluation of benefits and adverse effects of the treatment.

Independent support... You must have independent support for your diagnosis and treatment plan. This can be either in the form of a documented consultation with a specialist who treats "the anatomic area, system or organ of the body perceived as the source of the pain" or in the form of medical records from an appropriate specialist who has treated the patient previously and has documented the components described above. You should obtain and retain copies of records of all relevant previous medical treatment.

Informed consent... You must have an informed consent document signed by the patient that indicates the patient has been advised of diagnosis, planned treatment, anticipated benefits, possible

adverse effects, and available treatment alternatives.

Follow-up care... You must follow the patient at appropriate intervals, documenting any changes in the patient's functional status or quality of life, including ability to engage in work or other gainful activities, and any evidence of possible unlawful diversion of prescribed opioids. You are required to document all controlled drugs prescribed, dispensed, or administered in the medical record, including exact amounts, dosage form, instructions for taking them, and refills.

Drug screens... You are authorized to obtain a drug screen from any patient whom you think might be abusing drugs other than what you have prescribed, and must document the results of this testing in the patient's record. Refusal of drug screening by the patient is the equivalent of a positive test, and requires immediate consultation with an addiction or substance use specialist.

Professional courtesy/self-prescribing... Some additional rules relating to drug prescribing were passed at the same meeting of the medical board. One of these relates to writing prescriptions for oneself and for family members and other persons with whom a physician has a close personal relationship. "A practitioner may not self-prescribe or self-administer controlled substances... A practitioner shall utilize controlled substances when treating a family member only in an emergency which shall be documented in the patient's record." ■

Toke Action

This article appeared originally in the *Ohio Family Physician* and is reprinted with permission. For a full copy of the pain rules see the OSMA Web site, www.osma.org.

Robert Gillette, MD, Youngstown, is a family practitioner who served on the OSMA Ad Hoc Pain Advisory Committee, as well as editor of the pain treatment handbook.

Deadline for filing PIE claims extended

The deadline for filing claims against PIE Mutual Insurance Company has been extended to Sept. 23. Anyone with a claim against PIE must submit a proof of claim form to the Chief Deputy Liquidator of the Ohio Department of Insurance by the Sept. 23 deadline. This includes claims for return of unearned premiums and any other claims against PIE. If you need a form, you should contact: The PIE Mutual Insurance Company, c/o Office of the Insurance Liquidator, 1366 Dublin Road, Columbus, OH 43215. (614) 487-9200. ■

Ohio Medicine

A Publication of the Ohio State Medical Association

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Ohio Medicine (ISSN 0892-2454/USPS 405-200) is published monthly for \$40 a year by the Ohio State Medical Association, 3401 Mill Run Drive, Hilliard, Ohio 43026. Periodicals postage paid at Hilliard, Ohio and at additional mailing offices. POSTMASTER: Please send address changes to *Ohio Medicine*, 3401 Mill Run Drive, Hilliard, Ohio 43026.

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Your practice guide...

Advice and tips to improve your practice

Before you hire a physician's assistant...

PAs can lighten your workload, but you are responsible for the work they do. Here's what to know before hiring one for your practice.

Bringing PAs on board

You want to hire a physician's assistant to help with your practice. What's the first thing you should do? Check with the State Medical Board of Ohio. State law requires that you receive prior approval from the medical board before you employ a PA in your practice. A standard PA utilization plan must describe:

- the responsibility of the supervising physician;
- the duties of the PA;
- the circumstances under which a PA must refer a patient to the

physician;

- The procedure for the PA to write medical orders; and
- the procedures if the physician is not available and a patient needs immediate attention.

If you're still not clear how to write a utilization plan, the medical board has model standard utilization plans available.

Once your plan has been approved by the board, it does not expire. The plan remains valid until the physician notifies the board that it is no longer in effect, or it is replaced by a new plan.

Adding or changing duties

The PA is now a part of your practice and helping to decrease your workload. But now, you wish to make some changes in your utilization plan by adding responsibilities:

ties or changing the location where services are provided. Any time that you want to make a change in the way that you use the services of your physician's assistant, you must file a supplemental utilization plan with the medical board. This includes a change in:

- location;
- the functions and duties of the PA;
- the methods or procedures of the quality assurance plan;
- the type or degree of supervision and/or;
- any other information which is a part of the utilization request as approved by the medical board.

Supervision plans

Once your utilization plan is in place, and approved by the board, you must obtain the medical board's approval of a supervision agreement. The supervision agreement is signed by both you and the individual PA. It states that you agree to supervise the PA, and that the PA agrees to practice in accordance with the utilization plan approved for the physician.

You are not limited in the number of supervision agreements into which you may enter, but, legally, you may not supervise more than two PAs at any one time.

As supervising physician, you are legally liable for the services provided by a PA. In carrying out the duties of a supervising physician, you must:

- be available for communication, and be not more than one hour away;
- personally review the PA's activities;
- regularly review the condition of patients treated by the PA; and
- regularly perform any other necessary review.

PAs scope of practice

The scope of practice of a PA is broad. A PA may:



- take patient histories;
- perform physical, pelvic and rectal examinations;
- assess patients, order and perform routine diagnostic procedures and develop treatment plans; and
- carry out or relay the supervising physician's orders for medication, except as prohibited by the drug laws.

When writing medical orders, a PA must use forms which identify the supervising physician, and, unless provided in the approved utilization plan, the supervising physician must review each order within 24 hours after it is written, and countersign the order if it is appropriate.

Terminating PAs

When the physician's assistant ceases to be employed by you, you and the PA are required to notify the medical board within two days of the termination of a supervision agreement, and the reason for the termination ■

Take Action

This information is from the OSMA's legal fact sheet on Physicians and Supervised Assistants, which is available to OSMA members free of charge. You'll find the fact sheet on the OSMA's Web site [look under hot news.] Or order a copy by contacting the Ohio Medicine reader response line (800) 766-6762, Ext. 6580, and ask for item #6-99.

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Back-up your files

If your electronic files change daily or often, they should be backed up regularly, transmitted in encrypted form, and stored off-site.

Your medical office computer files may contain patient records, financial spread-sheets and personnel records. If they became damaged or inaccessible, or confidentiality were breached, your costs, liabilities and inconvenience could be appreciable.

"Your highest risk of problems comes from inside your own office, whether from user error, insecure passwords, disgruntled worker, or power failure," says Mike Dellar, director of Sales and Marketing for Jade Inc., a turnkey computer and Internet solution provider. "Backing up your files regularly, transmitting them in encrypted form, and storing them off-site is your easiest loss-reducer."



Which files and how often?

Not all files need to be backed up every day. For instance, your application programs are easily replaced, or duplicate CDs could be made just once (until you upgrade that part of the system). Files that change daily, or often, such as financial or patient records, should of course be backed up daily.

"Sometimes problems within the system aren't immediately evident, so you'll want to archive records of different ages, such as week-old and month-old," says Dellar.

Ease enhances compliance

Of course, the easier the process, the more likely it will be followed consistently. The simplest portable backup format is the floppy disk.

If you're using more than 10 floppies, depending on the amount of information to be stored, you'll want to consider such products as Zip and Jaz cartridge drives, various tape drives, or CD-ROMs. In addition to the media itself (tape, cartridge or CD), most forms require special hardware, as well as downloadable software (and software updates). Some compress data for faster transfer. You can also retrofit your personal computers with removable hard drives. All options are becoming more affordable.

Backups of different ages should be kept off-site in a place that is secure and accessible to more than one person 24 hours/day.

An even easier way to backup is by contracting with a credible outside service. Computer services can make sure your computer infrastructure is capable of automatic backup and electronic transmittal of information to off-site storage in an encrypted environment. If your infrastructure is not appropriate, they can suggest alternatives, or quote the required upgrades.

Encryption at the source (your office) provides secure transmittal and storage; security varies with type. According to Dellar, "The higher the level of security, the higher the level of inconvenience to you. Get only what you really need."

Your computer adviser will also assess your needs by information quantity, backup frequency and length of time kept to determine storage cost. — Carol Larimer

Medicare's most frequently asked questions

Q: Medicare is secondary for an End Stage Renal Disease patient. Should Medicare be billed directly for services unrelated to the End Stage Renal Disease?

A: When it is determined that Medicare is secondary for a patient, Medicare becomes secondary for all services. This includes services unrelated to End Stage Renal Disease.

Q: Can Medicare be billed directly for services that we know the primary insurer will never pay, such as pre-existing conditions, office visits (when applicable), and services for which the maximum limit has been met?

A: When Medicare is secondary, an Explanation of Benefits (EOB) statement from the primary insurer must be submitted with each claim. In certain cases, a letter of documentation from the primary insurer may be acceptable. This could occur in the situations mentioned above, where the primary insurer has documented in the letter that the identified service will never be covered by the plan and why. The information provided must be specific, i.e. office visits or a specific diagnosis. This letter can be kept in the patient's file at the provider's office and can be submitted to Medicare in lieu of an EOB. In cases where certain services will not be covered for a limited duration of time, the letter from the primary insurer must indicate the specific dates for which the services would be affected, i.e. "This patient has met his 1998 psychiatric limitation as of MMDDYY. Therefore, this insurance company will no longer consider any psychiatric services until MMDDYY."

Q: A patient is covered under an HMO insurance company. This provider's office is not included in the HMO approved provider listing. Will Medicare consider payment of these services?

A: No. Once we have notified a Medicare beneficiary that we will not consider payment for services provided by a non-network physician, no payment will be made for any future claims. The notification process can take place through a telephone conversation, in response to a written correspondence item, or when the first claim for this patient is submitted to Medicare. Once the patient has been notified, his/her records are documented so that Medicare will not consider any future claims for this type of payment.

This information was provided by Gary W. Zapf, manager, Medicare Secondary Payor Section. If you have a question about Medicare, in general or as a secondary payor, contact Bill Fry (Ext. 6760) or Jennifer Hyle (Ext. 6757) in the OSMA Department of Ombudsman Services, (800) 766-6762.

Colleagues

Newsmakers

ALVIN CRAWFORD, MD, Avondale, was elected first vice president of the Scolios Research Society at the annual meeting in New York.

Portrait

Cincinnati allergist Jonathan Bernstein, MD, identified a need when he recommended environmental control products, and patients asked where to find them.

After years of advising his patients on allergy relief and prevention, Jonathan Bernstein, MD, a Cincinnati-based allergist, wanted to bring something to the community of allergy sufferers. His idea for the One Stop Allergy Shop came to fruition in March 1998.

"I knew there was a definite need. When I recommended environmental control measures for my patients, I was frequently asked where they could find such items. It's hard to get a sense of what products do by looking through catalogs. I thought it would lend credibility if an allergist was involved with a shop of this kind, as well as bring the problem of indoor air quality to the forefront."

Twenty percent to 30% of the population is genetically predisposed to developing allergies. In the past 10-15 years, there has been an increase in the incidence of allergies and asthma worldwide. Ironically, technology and man's use of chemicals has lead to many cases of occupational asthma. "We're living in an era of chemical sensitivity," says Dr. Bernstein. Problems are prevalent in Cincinnati due to the Ohio Val-

ley and the effects of thermal inversion, barometric pressure changes and local industry.

By speaking with people, Dr. Bernstein got a sense of the types of allergy relief products they were buying or would purchase if the items were readily available. Using the Internet, he was able to locate products not easily found elsewhere, and by purchasing directly from the manufacturers, he is able to keep prices affordable for customers. Items can be purchased in person by catalog, and soon customers will be able to access products through the shop's Web site at www.stopallergy.com.

Products at the One Stop Allergy Shop include air filtration systems for homes, dehumidifiers, deodorizers, carpet and pet care products, as well as bedding encasings, comforters and pillows. Customers are given a "home assessment" sheet to help them identify allergy hazards.

The response to the shop has been positive. Dr. Bernstein hopes it will be both educational and convenient. The shop also promotes other allergists by displaying physicians' business cards and a map indicating their location. In addition to his practice, Dr. Bernstein is an associate professor at the University of Cincinnati and conducts workshops at the American Academy of Allergy, Asthma and Immunology as well as research in pharmaceutical products — Pamela J. Willits



Armando B.
Damian, MD

serve as 1999 officers are: President-Elect, nephrologist Jamal Azem, MD, Willoughby and Secretary-Treasurer gastroenterologist Ahmad Ascha, MD, Mentor.

DAVID P. KESEG, MD, Columbus, was named president of The Ohio Chapter of the American College of Emergency Physicians (ACEP) at the recent annual meeting held in Deer Creek, Ohio. Dr. Keseg, an Ohio native, will serve in this office for a one-year term.



David P. Keseg,
MD

ALLAN R. KORB, MD, Columbus. The Columbus Medical Association Foundation recently received its first physician donation since it began its formal grant-making process five years ago. Columbus psychiatrist and CMA member Dr. Korb made a significant monetary gift to the CMA Foundation to create the Allan R. Korb, MD, Fund. The fund is the first component fund of the foundation and will help support local health area initiatives.

DIYA F. MUTASIM, MD, Cincinnati, has been appointed director of the Department of Dermatology at the University of Cincinnati College of Medicine.

ROBERT H. OSHER, MD, Cincinnati, has received the 1998 Senior Honor Award from the American Academy of Ophthalmology.

ROBERT REBAR, MD, Cincinnati, professor and director of the University of Cincinnati Department of Obstetrics and Gynecology received the William Health Byford Award.

Obituaries

SYDNEY S. DEUTCH, MD, Dayton, Tufts University School of Medicine, Boston, 1934; age 92; died Jan. 5, 1999.

DAVID C. HUMPHREY, MD, Chagrin Falls, University of Kansas School of Medicine, Kansas, 1943; age 80; died Jan. 19, 1999.

PAUL KEZDI, MD, Dayton, Orvosi Fakultat Tudományegyetem, Budapest, Hungary, 1942; age 84; died Jan. 6, 1999.

LOUIS LIEDER, MD, Cleveland, Case Western Reserve University School of Medicine, Cleveland, 1930; age 92; died Jan. 24, 1999.

DAVID MARSALKA, MD, Columbus, Ohio State University College of Medicine, Columbus, OH, 1980; age 43; died Jan. 4, 1999.

RALPH ROSEWATER, MD, Cleveland, Ohio State University College of Medicine, Columbus, OH, 1934; age 90; died Jan. 10, 1999.

ROBERT M. WILSON, MD, Middletown, Ohio State University College of Medicine, Columbus, OH, 1940; age 90; died Jan. 13, 1999.

ROBERT A. WILTSIE, MD, North Ridgeville, Case Western Reserve University School of Medicine, Cleveland, 1953; age 74; died Jan. 20, 1999.

**Russell Dean heads
Academy of Medicine of Cincinnati**

The February issue of *Ohio Medicine* incorrectly identified Russell Dean, executive director of the Academy of Medicine of Cincinnati, as the executive director of the Cincinnati Medical Association. *Ohio Medicine* regrets the error. ■

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3

—year legislators have
knowledge of
lth-care issues and they
looking to OSMA mem-
ta help educate them.



9

ber-prescribing" for Ohio patients is
hibited by new rules drafted by the
Medical Board of Ohio. The board
that prescriptions provided over the
net fall below the "minimal standards
are" required of Ohio practitioners.

11

As could receive a standing committee if
proposed resolution from the International
Medical Graduate Task Force is approved
delegates at this year's Annual
Meeting, to take place next month
in Cincinnati.

17

Internet health advice credible?
Study by a group of Columbus
doctors shows that information
ies in accuracy and reliability —
when the source is a health-
care provider.

18

Latest health-care fraud alert targets
venders who order durable medical
equipment.

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Ohio Medicine

OSMA offers standardized credentialing form on disk

The Physician-Health Plan Partnership Act requires health plans to use a standardized credentialing form. The form is now available to OSMA members on disk.

Thanks to the Physician-Health Plan Partnership Act, the law which became effective Oct. 1, 1998 and was developed with the help of the OSMA, health-insuring corporations (HICs), also known as HMOs, are now required to use a standardized credentialing form when credentialing Ohio physicians.

Physicians may access the state form through the Ohio Department of Insurance (ODI) Web site. You may access the ODI site from the OSMA's

Web site (www.osma.org). Go to the "links" section and click on Ohio Department of Insurance. But there are two disadvantages to procuring your form this way. Unless you have an Acrobat reader, you will be unable to download the form — and once you complete and download the form, you will be unable to correct or update any information for future use.

The OSMA, however, has made the state form more usable by making it available on a disk that can be loaded into your personal computer and updated as necessary. This disk is available only to OSMA members, as a benefit of membership. To order a disk, see "Take Action" below.

All HICs that are licensed by the ODI to do business in the state of

Ohio are required to use the new credentialing form. A list of these HICs is printed in a separate story on page 4. However, the law allows HICs up to 120 days after the Jan. 14 effective date of the rules to use the new credentialing form. After late May or early June, then, HICs should be using the new form. ■

Take Action

To order a disk with the standardized credentialing form, fax your name, address and phone number to the OSMA at (614) 527-6762 Attn: *Ohio Medicine* or e-mail your information to asca@osma.org

Cleveland Academy suing OSMA

For the second time in less than four months the Academy of Medicine of Cleveland (AMC) has filed suit against the OSMA in an attempt to regain its status as a chartered component society of the OSMA. The OSMA Council revoked the AMC charter in January as the result of a series of actions by AMC.

"We continue to be baffled by the actions of AMC," stated Lance Talmage, MD, OSMA president. "For the past several years AMC has been actively seeking to exempt itself from many of the rules and regulations contained in the chartered agreement between it and the OSMA, yet it has twice sued to retain this relationship with OSMA."

continued on page 4



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Bills, Laws & Rules

Meet the Freshman Class

New legislators vary in knowledge of health-care issues, but they are willing and even eager to hear from you on what's important to the health care of Ohioans.

Nearly two dozen new faces join the roster of the 123rd Ohio General Assembly in 1999. Three-quarters of them are newcomers to the House of Representatives. The rest are new to the Senate. They herald the first wave of significant change that term limits legislation has spawned. By the year 2000, term limits will mean a 50% turnover in both houses of the Legislature.

"These new legislators provide a potentially great opportunity to break out of political ruts that may have hampered certain health-care bills in previous sessions," says Krista Bistline, political affairs coordinator with the OSMA. "As physicians and organized medicine," she continues, "we can positively impact these lawmakers by establishing good relationships early in their term and continuing a good communications link thereafter."

First year is pivotal

"The challenge," says Bistline, "is to work successfully with these new legislators, some of whom are very much up to speed on health-care issues, and others who are mostly uninformed in health care or who simply have a different focus for their high-priority issues."

In December, the OSMA hosted a seminar and luncheon for legislators, to help orient them to medical issues, introduce them to practicing physicians, and give them an opportunity to ask questions in a casual setting.

Physicians need to organize
Rep. Steve Austria (R-Beavercreek), who comes from a family full of physicians, nurses, and dentists, likes

one-on-one meetings with physicians from his constituency. "What I like to hear is both viewpoints," says Austria. "I want to know who is on the opposite side (of an issue) and why. Too often we hear one side with one view about why the person is opposing an issue." He also said that, "The medical community is not well organized politically, as are the attorneys or the insurance industry... and they need to be."

Austria, like many legislators, would be amenable to get-togethers in the home district. He, like others, would willingly meet a group of physicians for an hour or so of informal discussion over breakfast or coffee.

"Friends" carry more weight
Rep. Bryan Flannery (D-Lakewood) is knowledgeable about issues related to the hospital in his hometown. "I'm not going to know about all the (health care) issues, but I will listen and talk," he says. "I would like to see physicians get involved," he adds. Flannery encourages physicians to identify their legislators, meet with them, and continue to meet or pass information back and forth. "If I am familiar with you, I will give more weight to your comments." Flannery likes letters, short and to the point, and e-mail. He tries to respond to all of them. Many lawmakers will ask for comments and advice from physicians who are well-known to them.

One of the things that Rep. James M. Hoops (R-Napoleon) appreciates is publication clippings, with key points highlighted. He says, "Issues get tech-

nical and we, as legislators, need to talk about things. We need to process information from all sides. Health care has two viewpoints," he says. "The horizontal view is when you are lying in a hospital and the vertical view is when you're healthy and standing upright. You want to do the best in each situation, but there is always a fine line on the cost." He expressed an interest in getting information through anecdotal examples – real-life situations, not generalities, about things that happened to a person, a patient, in the district and how it impacts various aspects of the health-care system.

For physicians who want to get more involved in communicating with their legislators, and want to have more of a say in issues such as the Patient Protection Act, the first step is establishing a communications link. Bistline says that the OSMA will gladly help set up meetings if a physician wants to meet with a legislator. "But the best approach is to get together with that legislator in the district. Talk to them when you don't have a problem or want something," she advises.

As Austria states: "We need to hear about an issue ahead of the bill being put on the (House) floor, not in a reactive way after a bill has passed or been defeated." With the potential of a highly charged series of issues facing the new session of the General Assembly, the perfect time to get acquainted with new legislators is now.

– Yvonne H. Bury



Rep. James Hoops

Political activists wanted

Organized medicine needs your political involvement. Now. Here's how you can become active in the political arena – without leaving the comfort of your practice.

OMPAC

The Ohio Medical Political Action Committee (OMPAC) supports the political activities of the OSMA by supporting candidates who understand and vote for the views of organized medicine. In addition, OMPAC also educates physicians on political events and elections and fosters greater political participation by physicians. Contributions can be made at different levels, although OMPAC is always seeking members for its "300 Club," reserved for donors who contribute at least \$300.

PLAN

The Physician Legislative Action Network (PLAN) is a grassroots organization of physicians who support and sometimes oppose health-care legislation by contacting their legislators and presenting the views of organized medicine. You will be given information about the legislation, and sent alerts when the passage of a bill appears imminent. In politics, numbers count, especially at the grassroots level, so PLAN always welcomes new members to its ranks. ■

Take Action

For more information, or to join either or both of these groups, contact Krista Bistline, OSMA Department of Legislation, (800) 766-6762, Ext. 6580, and ask for item #7-99.

Cleveland Academy

continued from page 1

At issue is unified membership. Since its inception in 1846, the OSMA Bylaws and the bylaws of all of its chartered county medical societies, including AMC, required unified membership. Under this arrangement, neither the county medical society nor the OSMA may accept a member who does not join the other group.

The OSMA House of Delegates, which sets policy for the association, has reviewed the unification requirement several times over the past few years and thus far has voted to retain unified membership. In its meetings in 1997 and 1998, the delegates debated the report of the OSMA Task Force 2000, which was formed in part due to a request by AMC, to study membership issues, including de-unification. The task force recommended de-unification and a number of other changes to the governance process, but in May 1998, the majority of delegates voted against that part of the request.

However, despite the May vote reaffirming the unification policy, in September AMC sent out its 1999 membership dues bill, giving Cuyahoga County physicians the choice of joining AMC without also joining the OSMA — a direct and intentional violation of both OSMA policy and its bylaws.

*AMC seems to view de-unification

as the only solution to its rapidly decreasing membership. We are also concerned about this problem since it directly affects OSMA membership and over the past two years we have attempted to work with AMC to help resolve this problem," Dr. Talmage pointed out. "However, we can not stand by and ignore a direct violation of our bylaws."

In November 1998, the OSMA Council voted to revoke the AMC charter because of the unauthorized membership offer contained in its September dues billing. AMC immediately filed a lawsuit to overturn the revocation. In December, with the hope of resolving the problem, OSMA asked AMC to participate in a formal mediation process.

The resulting mediation agreement included the stipulations that AMC could not accept local physicians as members unless they also joined the OSMA. In addition, AMC agreed that it would not market its newly created Northeast Ohio Medical Association (NOMA) to any physician outside of Cuyahoga County. AMC created NOMA to solicit physicians outside of the unification requirement. However, surrounding county medical societies expressed concern to OSMA that NOMA would attempt to lure away their members.

In January of 1999, AMC violated the agreement by soliciting membership for NOMA throughout northeast

Ohio. Since a provision of the mediation agreement permitted immediate action if the terms were violated, at its January meeting, the OSMA Council voted unanimously to revoke the AMC charter. AMC subsequently filed suit to overturn the revocation.

During the January meeting, the OSMA Council also voted to activate the Cuyahoga County Medical Society as its component county medical society

in Cuyahoga County. This action was necessary because the OSMA, to comply with its own bylaws, must have a local society for physicians to join in order to comply with its unified membership requirement.

"We did everything possible to avoid this situation," states Dr. Talmage. "But by violating both its OSMA-issued

continued on page 21

It's about the members

As president of the OSMA I am often asked why we have taken certain actions. Some questions are accusative but most seek information to gain understanding. My answers always start with "We did it for the members." As a voluntary organization there can be no other reason. Members expect an advantage which cannot be obtained as an individual from a smaller group or a less peer-focused group. These benefits include volume discounted products, focused education, group projects to help others and demonstrate our concern for quality health care. Most of all members want realistic ethics advocacy in the halls of government and a group identity which projects professionalism and added value to our society.

Our federated state of democratic governance was borrowed from the system our country's forefathers adopted more than 220 years ago. For more than 150 years the OSMA has accepted majority rule while insuring that the minority can be heard and become a new majority if they work within the value system and successfully argue the logic of their position.

As I have said in other articles, your council takes its role of advocating for the membership very seriously and strives to uphold the policies of the House of Delegates. They also have the fiduciary responsibility to keep the organization viable and focused on needs of the members. In past issues, the members' needs were always paramount. In the Physician Insurance Company of Ohio (PICO) issue the company no longer served the members as it was created to do and we could no longer be a part of its board. With the Physician Insurance Exchange (PIE) we endorsed an insurer

which was overwhelmingly favored by our members and this arrangement helped us avoid a dues increase. We were watchful as was everyone else by the Ohio Department of Insurance endorsement of financial reports and an A.M. Best rating system which is not linear (B- was a pretty good grade in medical school) but based on a threshold. But we weren't prepared to deal with criminal fraud. On the bright side, we built a headquarters which is usable by our members and improves day to day staff interaction and productivity. And we financed it in a market that builds equity at lease payment rates. In addition it is sited on appreciating excess land which could one day result in a tidy profit for the OSMA.

Finally, I am asked what about the problems in Summit and Cuyahoga counties. I respond: it's still about the members. We could simply have walked away and said do as you choose but that would have left thousands of physicians without access to products and services OSMA can provide. It would have disenfranchised them in the deliberations and political action which require unity of purpose to be successful. To recruit members outside of our bylaws is unacceptable for an ethical organization. Other counties were threatened with members being solicited for a "cheaper deal" and weakening their local programs. Many counties objected because their members feel that unity strengthens and separation weakens all of us. The OSMA is about members. Until the House of Delegates decides we need a new governance structure we will work within our bylaws to serve every member physician in Ohio who joins us in concern for quality patient care and professional integrity. — Lance Talmage

HICs required to use standard credentialing form

Advantage Health Plan
Aetna U.S. Healthcare, Inc.
Anthem Blue Cross & Blue Shield
AultCare HMO
Bethesda Managed Care
Dayton Area Health Plan
Emerald HMO
Family Health Plan
Genesis HealthPlan
The Health Plan
Health Power HMO
HomeTown Health Plan
Kaiser Permanente
Medical Value Plan
ChoiceCare/Humana
Cigna HealthCare of Ohio
Community Health Plan of Ohio
Day-Med Health Maintenance Plan
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Healthsource Ohio
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Mutual of Omaha HealthPlans
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Nationwide Health Plans, Inc.
One HealthPlan of Ohio, Inc.
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Patient Protection may be close to passing in House

The bill's sponsor wants to have House Bill 4 move ahead of the budget which was unveiled in the House March 15. That means HB 4 could be forwarded to the Senate soon.

House Bill 4, referred to as the "Patient Protection Act," may be on its way to the Senate soon. House Bill 4, actively supported by the OSMA and Gov. Bob Taft, would hold health insuring corporations (HICs), also known as HMOs, responsible for any harm to an enrollee, caused by the HICs failure to exercise ordinary care in making a health-care coverage decision.

"House Bill 4 is the next and hopefully the last step in the process of health-care reform," Tim Maglione, OSMA legislative director, told legislators at a House Health Committee hearing recently.

Nick Lashutka, OSMA deputy legislative director, says the bill is on a tight timetable. "The bill's sponsor wants to have the bill move through the House before the state budget is unveiled. That will happen March 15, which means the bill could be on the House floor at the end of April or in early May." Rep. Randy Gardner (R-Bowling Green) is sponsoring HB 4.

When it leaves the House, the OSMA hopes it contains a point-of-service provision that will increase patients' access to their chosen physicians. "At this point, the provision isn't in the bill, but we hope it will be before it leaves the House floor," says Lashutka.

Although most physicians support HB 4, Rep. Rose Vesper (R-New Richmond) said at one committee hearing that she has received letters of concern from doctors who think the bill, as it is written, would lead HMOs to "micromanage" their practices. But Maglione pointed out to the committee that Texas, which has a similar HMO liability law already in place, has not seen any indication so far of such "micromanaging." ■



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New Healthcare Legislation

The following bills have been introduced since the deadline for the March issue. Where appropriate, an OSMA staff member and extension number is listed for those who would like more information about the bill. Call (800) 766-6762, and ask for the extension you need.

Senate Bills

Senate Bill 55. County hospitals SB 55 makes changes regarding the authority of boards of county hospital trustees.

Sponsor: Sen. Doug White
(R-Hillsboro)

OSMA contact: Krista Bistline, Ext. 6748

OSMA position: Under advisement

Senate Bill 56. Rural hospitals

A companion bill to House Bill 158, this bill would allow hospitals to employ physicians.

Sponsor: Sen. Doug White
(R-Hillsboro)

OSMA contact: Krista Bistline, Ext. 6748

OSMA position: Neutral with technical assistance

Senate Bill 74. Medical Record Fees
This legislation specifies the fees that health-care providers may charge for providing medical records. It also provides that a medical records company must be formed as a domestic corporation and specifies that a medical records company is subject to regulation by the Department of Commerce.

Sponsor: Sen. Louis Blessing
(R-Cincinnati)

OSMA contact: Marla Bump, Ext. 6741

OSMA position: Opposition

Senate Resolution 77. Reproductive health facilities

This resolution (a resolution, if passed, is affirmed by the Legislature but is not placed in statute) condemns acts of violence against reproductive health-care facilities and exhorts law enforcement officials to continue efforts to prevent and investigate such acts, and to prosecute those responsible. In a recent hearing, the bill's sponsor, Sen. Linda

Furney (D-Toledo) cited several incidents in which doctors, nurses and innocent bystanders were killed or seriously wounded in attacks on abortion clinics. "Regardless of our positions on abortion, we have to agree that violence has no place in the public policy debate," she says.

Sponsor: Sen. Linda Furney (D-Toledo)

House Bills

House Bill 88. Insurance Tax Credit
Among other things, HB 88, if passed, would allow a tax credit for a portion of the premiums paid by an individual for long-term care insurance.

Sponsor: Rep. George Terwillegger
(R-Maineville)

OSMA contact: Nick Lashutka, Ext. 6747

OSMA position: Support

House Bill 90. Alternative Medical Treatment

If passed, HB 90 would permit physicians to use alternative medical treatments if the risk of harm is reasonable when compared to potential

benefits, the patient provides informed consent, and the treatment is consistent with the standards enforced by the State Medical Board.

Sponsor: Rep. George Terwillegger
(R-Maineville)

OSMA contact: Marla Bump, Ext. 6741

OSMA position: Under advisement. Lack of a definition of "alternative medicine" concerned OSMA's Committee on State Legislation. Members also believe the State Medical Board of Ohio should be asked to develop guidelines or a position statement establishing standards.

House Bill 121. Asthma Inhalers

HB 121 permits students of school districts, community schools and chartered nonpublic schools to carry asthma inhalers approved by the students' physicians and parents and grants immunity to school districts, community schools, and chartered nonpublic schools and their employees for good faith actions in connection with this permission.

Sponsor: Rep. Randall Gardner

(R-Bowling Green)

OSMA contact: Marla Bump, Ext. 6741

OSMA position: Support

House Bill 138. Statewide trauma system

Like its predecessor, HB 38 would establish a statewide trauma system in Ohio, but the bill's sponsor, Rep. William Schuck (R-Columbus), has made a change. This time, hospitals would not have to be verified as trauma centers by the American College of Surgeon (ACS). Instead, the Ohio Department of Health (ODH), which would be required to develop quality rules and standards for trauma care, could also designate hospitals as trauma centers. Those hospitals not verified by ACS would have to be inspected by the ODH every three years.

Sponsor: Rep. William Schuck
(R-Columbus)

OSMA contact: Marla Bump,

Ext. 6741

OSMA position: Support

House Bill 148. Handicapped parking
If passed, HB 148 would increase the penalties for a violation of the special parking privileges established for persons with certain disabilities and makes

continued on next page

House Bill 138

Trauma bill reintroduced with less controversy

The new version of a bill calling for a statewide trauma system narrows the definition of trauma, but allows emergency crews and individual hospitals to decide where pediatric trauma patients should be sent.

Rep. William Schuck (R-Columbus) has reintroduced the trauma legislation he was unable to move past debates in the House Health Committee last year. The new bill, House Bill 138, will establish a statewide trauma system if passed, but gone are some of the previous bill's sticking points.

For example, the new legislation:

- Defines trauma as an injury that creates a risk of loss of life or
- Places the ODH in charge of trauma care in hospitals.

- Sets rules for a statewide registry

limb, or significant, permanent disfigurement or disability.

- Requires nontrauma hospitals to have written transfer agreements with trauma hospitals. Nontrauma hospitals would be able to stabilize trauma patients, but not admit them for care.
- Permits hospitals to seek trauma verification through the American College of Surgeons or through the Ohio Department of Health (ODH).
- Authorizes the state Emergency Medical Services Board and a new trauma committee to write rules regarding triage and transportation of trauma patients.
- Places the ODH in charge of trauma care in hospitals.
- Sets rules for a statewide registry

that tracks trauma patients from injury through rehabilitation.

- Defines pediatric patients as those 16 years and younger, but would not mandate that these patients be sent to pediatric trauma centers (a decision that has disappointed children's hospitals across the state.)

The bill stands a better chance of passing this year, say analysts. If it does, Ohio will become the 28th state, in addition to the District of Columbia, to have a statewide trauma system.

Sponsor: Rep. William Schuck (R-Columbus)

OSMA position: Support

changes in the application process for removable windshield placards.
Sponsor: Rep. Bryan Williams
(R-Akron)
OSMA contact: Marla Bump, Ext. 6741.
OSMA position: Neutral with technical assistance

House Bill 151. Insurance coverage appeals

This measure gives the state health director the authority to adopt rules relative to enrollee appeals of denials or reductions of health-care coverage, and grants the director of insurance the same authority.

Sponsor: Rep. J. Donald Mottley
(R-West Carrollton)

OSMA contact: Nick Lashutka, Ext. 6747

OSMA position: Support with technical assistance

House Bill 158. Rural hospitals

If passed, HB 158 would permit rural hospitals to employ physicians, but the bill also mandates that employers do not interfere with the professional judgment of the physicians employed.

Sponsor: Rep. Bill Ogg (D-Portsmouth)
OSMA contact: Krista Bistline,
Ext. 6748

OSMA position: Neutral with technical assistance

House Bill 173. Health insurance

This bill requires policies, contracts, and agreements of health insuring corporations and sickness and accident insurers to cover, under certain circumstances, general anesthesia and hospital services connected with the provision of a dental care service to an insured or enrollee.

Sponsor: Rep. Cheryl Winkler
(R-Cincinnati)

OSMA contact: Nick Lashutka,
Ext. 6747

OSMA position: Under advisement ■

Take Action

Members can check the OSMA Web site, www.osma.org for an update of new bills introduced in the Ohio General Assembly. You may also check the status of current bills on the OSMA site. Go to the links page, and click on *Ohio General Assembly* listed under "Government/State." The link will allow you to type in the number of the bill. Once you've made your selection, the entire bill will be displayed.

Educational program planned for medical students

The board would like to develop a program that's designed to prevent some of the ethical and other problems it hears on a regular basis.

Anita Steinbergh, DO, president of the State Medical Board of Ohio, hopes to familiarize third- and fourth-year medical students, as well as house staff, with the workings of the medical board.

The goal, she told board members, is to prevent some of the problems that come before the board.

Barbara Ross Lee, DO, Dean of Ohio University College of Osteopathic Medicine, has already been approached about helping to develop and fund a program that could be a tape or some sort of interactive computer program that presents the medical board's mission, as well as personal and professional ethics and physicians' responsibility to the board. In coming months, the board will seek commitments for the project from other medical school deans, with the goal of making the program a part of the ethics curriculum for all medical students in Ohio.

Medical Board Report

Information about the program is available on the medical board's Web site: www.state.oh.us/med.

Of note...

Supplemental PA plan application is revised... The medical board approved a revised supplemental PA application, submitted by its PA committee. As part of the new application, a separate parts I and II will have to be completed for each duty, and applicants will be asked to indicate either 100% supervision of PAs, or offer an explanation if less than 100% supervision is anticipated.

Legislation brought to board's attention... Two legislative proposals have come to the board's attention. One bill would mandate insurance companies to reimburse physicians for prostate specific antigen PSA tests and

digital rectal exams, the other was a possible reintroduction of last session's House Bill 633. This legislation would ask the pharmacy board, the medical board and other appropriate individuals to develop a list of drugs that may not be substituted without physician consent. Under current Ohio law, pharmacists may substitute a prescription with a different drug or generic without letting the physician know or agree. The proposals were discussed primarily to alert board members to upcoming legislative issues.

Committee moves forward on laser use rules... The board's Minimal Standards of Care Committee continues to discuss the use of lasers for hair removal, and hopes to begin the rule making process next month. The committee is currently compiling information provided by various individuals for review prior to making its recommendations, and is accepting information from anyone who wishes to provide it. Among issues under discussion: who is qualified to use lasers, and should there be supervision of nonphysicians who use lasers? ■

Rules would prohibit Internet prescribing

The State Medical Board of Ohio says "cyber-prescribing" falls below the minimal standards of care and is drafting rules to prohibit the practice.

The State Medical Board of Ohio does not want Ohio physicians prescribing drugs over the Internet, and has drafted rules to prohibit the practice. That makes Ohio one of the first states to address Internet prescribing.

Although only a few Ohio physicians engage in "cyber-prescribing," the board is eager to nip the trend early. "We feel this practice falls below minimal standards. Web sites, perhaps recognizing the potential for liability, require patients to agree to waivers before drugs can be ordered. The waivers are an effort to prevent

Tom Dilling, the board's government affairs officer told *The Columbus Dispatch* recently.

Most of the drugs prescribed over the Internet are what Dilling describes as "embarrassment drugs" — Viagra, Propecia, Zyprexa and Meridia. But, as Dilling notes, "They are prescription drugs for a reason."

The board expects physicians to physically examine patients and make a diagnosis before prescribing any drug. Otherwise, the practice falls below minimal standards. Web sites, perhaps recognizing the potential for liability, require patients to agree to waivers before drugs can be ordered. The waivers are an effort to prevent

the consumer from filing lawsuits for any side effects that develop.

The board has indicated a few exceptions to its proposed rules on cyber-prescribing. Doctors can use the Internet to prescribe drugs for: 1.) patients admitted to institutional settings; 2.) patients of a colleague during on-call situations; and 3.) times when one physician has agreed to see another's patients.

If adopted, the rules would apply not only to Ohio physicians but also to physicians from other states who prescribe over the Internet to Ohio consumers.

Frontier vows rates will be adequate, fair

To the Editor:

I had the opportunity to read the article printed on page 20 of the February 1999 issue of *Ohio Medicine* regarding the pricing policy of Frontier Insurance Group.

While it is true a review of our loss development in a number of states revealed some inadequacies in our rates, adjustments to premiums were made following regulatory approval effective 10/1/98 on new businesses and 1/1/99 on renewal business. It is the intent of the new management team at Frontier HealthCare that rates be adequate and fair at all times in order to assure the stability of Frontier to the market.

It is also true Frontier Insurance Group took a \$150 million charge in the fourth quarter reflecting a corporate commitment to adequacy of reserves and to cover all the costs of restructuring our HealthCare Division.

Frontier Insurance Group, through its newly created HealthCare Division, has made a commitment to Ohio and will continue to offer professional lia-

bility coverage for physicians at rates that will enable us to continue as a financially strong player in a market that is extremely volatile. Policyholders in Ohio should be reassured that A.M. Best, after a thorough review of Frontier Insurance Company, has reaffirmed it's A- rating without qualification.

Edward J. Kupcho
Vice President, Field Operations
Frontier HealthCare

From HOME REMEDIES To HMOs



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Coding committee needs to clarify "consultation"

To the Editor:

I read with interest the article in the "Practice Tips" section of the February issue in which Jillian Phillips comments on the consult/referral coding issue. Jillian is the unquestioned state expert on these issues, but in this case, she has been influenced by third parties who are reinterpreting the meaning of the CPT book to serve their needs.

Consultation codes were devised as part of a CPT coding scheme, designed to pay physicians based on factors including cognitive effort, work, time and supplies needed to provide care. Consultation codes are reimbursed at a higher level because cases requiring referral/consultation are, on average, more complex than cases routinely handled by the primary care physician. In addition, a report must also be gen-

erated by the consultant and sent to the referring physician which requires effort and time.

Any follow-up care provided by the consultant should *not* be billed as a consultation, but the initial referral certainly is a consultation! It would be a tricky system if the code was determined by the consultant, only after communicating with the referring doctor. This would require yet another phone call during each patient visit. It cannot be handled on a referral form because the referring doctor can't know who is going to provide the follow-up care until after the consultant analyzes the situation and provides a diagnosis and/or treatment plan.

I beg the AMA coding committee to clarify this issue in the next edition of the CPT manual. Let's not allow HCFA to redefine the meaning of consultation. The term is clear to anyone who has been to medical school.

Robert T. Brodell, MD
Warren



letters

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OSMA News

1999 House of Delegates Resolution

Title: OSMA IMG Committee

Submitted: OSMA Council and IMG Task Force

WHEREAS, There are 155,000 international medical graduate (IMG) physicians in this country, comprising 24% of all physicians; and

WHEREAS, 25% of IMGs are members of the American Medical Association (AMA), 60% are members of the Ohio State Medical Association (OSMA), and more belong to their local, state and specialty societies; and

WHEREAS, iMGs have unique cultural, professional, and social concerns that have caused barriers to their ability to succeed professionally and socially, and become more productive, contributing members of the medical profession and organized medicine; and

WHEREAS, The AMA has been aware of the unique problems IMGs face and, in its effort to be a more inclusive organization, established a membership section for IMGs in 1998; and

WHEREAS, The AMA IMG Section has been an active body since its inception and has caused awareness about the AMA in the IMG community and has resulted in an increase in membership to the AMA and IMG involvement in organized medicine; and

WHEREAS, The OSMA, aware of similar issues, wanted to reach out to all IMGs in the state and established an IMG Task Force, and ad hoc committee, in 1991; and

WHEREAS, The OSMA IMG Task Force, active since its inception, has been the sounding board for IMG concerns and has created renewed interest in belonging to organized medicine and more involvement in

its activities amongst iMG physicians in the state; therefore be it

RESOLVED, That the OSMA IMG Task Force be made a permanent (standing) committee of the Ohio State Medical Association; and be it further

RESOLVED, That the OSMA Bylaws be amended to include the following by addition:

Chapter 9, Section 1. Committees. The standing committees of this Association shall be the Committee on Auditing and Appropriations, and the Committee on Judicial and Professional Relations AND THE COMMITTEE ON INTERNATIONAL MEDICAL GRADUATES. All other committees and task forces of this Association shall be appointed by the President.

Fiscal Note: \$13,850 (Note: No increase over 1999 approved OSMA IMG Task Force budget.)

Annual Meeting held in May

The OSMA's Annual Meeting will be held May 14-16 in Cincinnati.

May 14

1-4 p.m. – Organized Medical Staff Section Educational Meeting

May 15

10 a.m. – Opening Session HOD
1:30-5 p.m. – Resolutions committee hearings

May 16

10 a.m. – Final Session of HOD

For a complete schedule, visit the OSMA Web site at www.osma.org.

Polsley runs for AMA office

J. Steven Polsley, MD, Urbana, is running for a seat on the AMA Council on Medical Service. His candidacy is enthusiastically endorsed by the OSMA and the Ohio Delegation to the AMA.

Dr. Polsley is a board-certified family physician, and the president of a rural, five-member family practice group. He has been in active, full-time practice since 1973, yet has found time to serve organized medicine at the local, state and national levels for more than 15 years. His service includes roles as: Champaign County Medical Society president; Second District Councilor to the OSMA; OSMA alternate delegate and delegate; and member of the Ohio Delegation to the AMA.

In addition to organized medicine, Dr. Polsley has been actively involved in the profession itself. He has been chief of staff at Mercy Memorial Hospital; a trustee on that hospital's board; and an associate professor of family practice at Wright State University. He is also a medical adviser to the local paramedics, and serves as president of the paramedics board of directors.

His community activities include service on the Urbana University Foundation Board, the Grimes Foundation Board, and his church board.

Dr. Polsley is also endorsed by the American Academy of Family Physicians, the Ohio Academy of Family Physicians, and the Champaign and Montgomery County Medical Societies.

His campaign theme is: Creative Solutions, Traditional Values. ■



J. Steven Polsley, MD

Hot News Headlines

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If you have an e-mail address and would like to get the latest Ohio health-care news delivered FREE to your computer on a weekly basis, send your e-mail address to kkirk@osma.org



OSMA Happenings

OSMA legislative directories available... The OSMA Department of Legislation has its 1999 Legislative Directory available, and will distribute them to all members of the Physician Legislative Action Network (PLAN) and the Ohio Medical Political Action Committee (OMPAC). The directories list the names, addresses and phone numbers of all Ohio representatives and senators, as well as committee assignments. If you are an OSMA member who is not a member of PLAN or OMPAC, you may request a copy of the directory by contacting the *Ohio Medicine* reader response line, (800) 766-6762, Ext. 6580, and ask for item #8-99.

Attention PLAN members...When you receive a legislative alert from the OSMA, it's important for you to extract the information from the alert and, in your own words, fax, phone or e-mail your legislator in support or opposition of the bill, as the alert directs. Do not fax the alert itself, because it may contain information that is not necessarily meant for distribution beyond the PLAN network.

Action report features all activities... OSMA staff has prepared its 1999 Action Report on 1998 Resolutions. Instead of reporting only on resolutions referred to Council, as required by the 1994 House of Delegates, the 1999 report features actions taken on all 1998 resolutions. The Action Report is available under "Hot News" on the OSMA Web site, www.osma.org, or OSMA members may request a copy by contacting the *Ohio Medicine* reader response line, (800) 766-6762, Ext. 6580 and asking for item #9-99.

Circle these Alliance dates...The OSMA Alliance has two important upcoming events to list on your calendar. Legislative Day, April 14 is designed to bring Alliance members into closer contact with legislators by placing them in their senators' or representatives' office for a two-hour volunteer work shift. Interested Alliance members should contact Sara Rich, Day at Legislature chair, (937) 293-6669 for more information. OSMA Alliance Annual Meeting is scheduled May 13-14 at the Westin Hotel, Cincinnati. For more information, contact Deborah Blackwell, OSMA Alliance office, (800) 766-6762, Ext. 6750. ■

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Alliance report Bylaws changes to be considered

O SMA Alliance Annual Session plans are well under way for May 13 and 14 in Cincinnati. Headquarters hotel is the Westin. The facilities are all redecorated and updated. It is connected by skywalks to other hotels and shopping.

Business of the convention will include OSMA bylaws changes. The first is to change the way in which member-at-large delegates to the House of Delegates are selected. Members-at-large are entitled to one delegate for each 100 members, or portion thereof. Current Rules of Procedure gives the president the authority to appoint the delegate(s). The bylaws change will make it an election by mail ballot to all members-at-large. Should no delegate(s) be elected, the president will then appoint.

The second bylaws change sets the guidelines for establishing a county alliance/auxiliary. There is no change in the requirement for affiliation with an OSMA chartered medical society, but to be an organized county, there must be written bylaws, officers and at least three members who have paid county and state dues.

OSMA Alliance will also be introducing resolutions on Tobacco Use Prevention, one to the House for Ohio policy and a second to be submitted to the AMA Alliance. The resolutions and the bylaws changes have been submitted to OSMA Council. If there are any questions, or if anyone wishes to receive copies, please contact OSMA Executive Secretary Deborah Blackwell, (800) 766-6762, Ext. 6750.

All OSMA members are invited to attend the OSMA Annual Session. The House of Delegates will be in session Thursday afternoon, May 13 and Friday morning and afternoon, May 14. Reference committees will hold hearings Friday morning, prior to the second session of the House. ■



Nancy Goorey
DDS

Holding HMOs accountable is step two in managed-care reform

According to an old saying, spring is when a young man's fancy strays to thoughts of love. For the OSMA, however, spring raises thoughts of health-care legislation. Unfortunately, a recent court decision means that school funding is likely to overshadow most other issues in the coming months.

Nevertheless, there are at least three important health-care bills (or soon-to-be bills) that will reach the legislators' attention: 1.) the Advanced Practice Nurses' push, once again, to secure prescriptive authority; 2.) the need for prompt payment of physicians' and other providers' bills by third parties (OSMA is initiating this legislation in view of the failure of the state's current prompt pay law); and 3.) House Bill 4, the Patient Protection Act that includes language on HMO accountability.

The first two issues (as of this writing, neither has been introduced as legislation yet) are matters on which the OSMA has House of Delegates' policy. The OSMA opposes prescriptive authority for APNs, and supports a tougher, more enforceable prompt-pay law. Our action on these bills will be dictated by our policy.

Meanwhile, the OSMA has taken a position of active support on House Bill 4.

I think it's important to note that we are not taking shots at all HMOs or insurance plans. We agree that some plans are run conscientiously. Yet we believe that if HMOs and other entities are going to make medical decisions for our patients (and most do), then they must be held accountable for those decisions. It's a simple matter of fairness. After all, we're the first ones held accountable if one of our medical decisions results in an adverse outcome, and now that patient-care decisions are being shifted to HMOs, we believe they should be held to the same stan-



Lance Tidmore, MD

President's Perspectives

dards. Payors talk about partnership with physicians, so let's truly be partners in benefits and risks.

Certainly, we're not fond of opening yet another area for plaintiff attorneys. We're willing to listen if HMOs have a viable alternative. Just don't tell us that HMOs only make "coverage decisions" and that HMOs are already accountable under contract law. The line between clinical decisions about necessary medical care and decisions about insurance coverage is particularly blurred in managed care. It's important that there be a link between medical necessity determinations and professional practice standards. The provisions of PHPA will hopefully help patients better understand and deal with their medical benefit plans, but immediate remedies must be available to the sickest of our patients.

And HMO accountability is a quality care issue. Of course, others may perceive our support of HB 4 as a pocketbook issue, but the truth is, we are concerned about the care our patients receive, and we think the best quality care is delivered when medical decision-making is done by those who are qualified, through education and experience, to make those decisions. Namely, physicians.

The Taft Patient Protection Plan also will require health plans to designate an Ohio licensed physician to act as the health plan's medical director. Because an incorrect determination that a medical service is not necessary may have severe consequences on a patient, the question of whether a given service is or is not medically necessary thus assumes a high level of importance. By requiring Ohio medical directors to hold an Ohio license to practice medicine, the State Medical Board of Ohio

On the Web...

Let us know what you think

The OSMA is using the Internet to get opinions from our members. If you've visited the OSMA Web site (www.osma.org) recently, you'll notice that we've implemented a pop-up survey component.

The survey pops up once on your screen and you have the option of either answering the survey or not. We hope you select the first option. On repeat visits to the site, the survey will only pop up if we have changed the questions and once again need your opinion.

This is a new way to reach our membership and nonmembers on a variety of subjects. The first survey requested information on the type of operating system you are currently using, information on your Internet service provider, Web browser and modem speed. This information will help the OSMA Web site staff better serve your needs. From time to time you may see questions on legislative issues, membership, and CME.

Membership services survey

The OSMA Division of Membership Services put together a survey that contains a list of several new products and services that have either been requested by members or that have been brought to the attention of the OSMA from outside vendors.

Members-only can complete the survey online and e-mail to the OSMA. If a positive response is received for any of these products and services, the OSMA staff will further investigate the product and select a provider that can best serve the membership. You'll find this survey by going to the OSMA site (www.osma.org) go to "Hot News" then scroll down to "News Roundup" and look for the story about potential new services.

Osteoporosis survey

The OSMA Web site also includes a needs assessment survey on diagnosing and treating osteoporosis – one of the five women-related illnesses that the OSMA will explore during its two-year Women's Health Initiative. The information gleaned from this survey will help develop educational materials for physicians on how to identify, treat, refer and communicate with their patients about osteoporosis. To complete this survey go to "Hot News" and look for "Diagnosing, treating osteoporosis."

Take Action

Comments and suggestions about the OSMA Web site are welcomed. Please e-mail Karen Kirk at kkirk@osma.org.

will continue to have comprehensive oversight of the laws governing the practice of medicine.

Your patients and other physicians need to know about this bill and the issues surrounding it. Talk to your patients and colleagues about House Bill 4. Tell them to express their concern to their legislators. The OSMA will help by spreading the word about HMO accountability through the news media, and preparing an information sheet you can copy and place in your office as a way to open the door to conversation with your patients.

Finally, I suggest you let your own thoughts stray, this spring, to ways you can support this bill. Talk to business friends who are employers about the need for this legislation. HB 4 does not make the employer liable; it just makes HMOs accountable for their medical decision-making. As I've already mentioned, talk to your patients and solicit their support. Finally, contact your own state representatives and tell them how important this bill is to managed-care reform in Ohio. If House Bill 4 passes, our patients (not our pocketbooks) will be better off. ■

Federation of Medicine

AMA Report

Fraud and abuse rules must be clear and fairly enforced

The AMA is working to ensure that medical professionals are not held to a standard that's unfairly higher than any other citizen or professional group.

By Herman A. Abramowitz, MD

The issue:

Fraud and abuse has become an issue. Almost overnight, the practice of medicine is being held to new levels of accountability that have little, if anything, to do with the provision of or even the quality of care that a patient receives. As physicians, clearly, we are against fraud and abuse. That's particularly true in the health-care setting where so much of what we do is based on the essential trust that needs to exist in the patient-physician relationship.

The government's new focus on fraud and abuse, however, has us concerned. The perception is that physicians and other health-care professionals are dishonest perpetrators of fraud. We know that's not true, but fraud and abuse rules and alerts continue to be drafted and now the government proposes a fraud and abuse data bank.

AMA's response:

How is the AMA addressing the fraud and abuse issues? Our response

is straightforward:

- 1.) Physicians are hardworking and honest professionals who place our patients' interests first, and we have zero tolerance for fraud and abuse;
- 2.) All fraud and abuse rules must be readily understandable and enforced in a fair and consistent manner for all citizens of this country. The AMA has asked the government, in a letter, to respond to the very real worry that a simple coding mistake will result in a criminal investigation and a \$10,000 fine for every improper claim. The AMA believes we must hold both the Health Care Financing Administration (HCFA) and its Office of the Inspector General (OIG) accountable to their declarations that "Physicians will not be punished for honest mistakes."
- 3.) Compliance information and other educational materials must be provided to physicians. The AMA has produced a publication, entitled *Federal Fraud Enforcement*



Herman A.
Abramowitz,
MD

— *Physician Compliance*, which assists physicians in understanding the issues related to fraud and abuse. In addition, it presents the essential elements of an effective compliance program. It's a roadmap, if you will, of how individual physicians can address the fraud issues in their own practices.

Our next step is the development of practical compliance tools.

The AMA is deeply concerned that unreasonable administrative barriers and improper perceptions are being erected between us and our ability to meet our patients' needs.

Just as physicians are held accountable for the care we provide, the AMA will continue to hold the federal government accountable if it takes unfair steps in exercising its enforcement authority. Just as the AMA has zero tolerance for fraud and abuse by physicians or anyone else, we have zero tolerance for unfair and unfounded hassling of physicians.

The AMA will continue to address these concerns, on your behalf, until they are resolved. ■

Herman A. Abramowitz, MD, Dayton, is a member of the AMA Board of Trustees.

AMA denounces AARP fraud campaign

The AMA blasted the recent "fraud campaign," launched by the American Association of Retired Persons, that urged Medicare patients to contact a toll-free fraud hot line if they suspected improper billing by physicians, hospitals and other health-care providers.

While the AMA says it has zero tolerance for genuine fraud, it calls the campaign launched by the AARP and

the federal government as "ill-focused and simplistic."

"A far better approach would be for government officials to work with physicians, hospitals and other providers to focus on documented abuses, and to develop targeted strategies for rooting out fraudulent conduct," the AMA says. "It is counterproductive to demonize the entire medical community with the broad

brush of fraud, waste and abuse."

The AMA also called on Medicare officials and contractors to simplify forms and regulations so patients and physicians can understand them, and to increase educational programs designed to enable physicians to comply with thousands of forms and documents.

From the county files...

Original Tar Wars program still going strong

Last month, the poster contest for "Tar Wars VII" was held at Franklin Park Mall. Celebrity judges chose two winners — a fifth-grader and a schoolchild from the "open division" (kindergarten through grade 12) — to receive grand prizes of a \$500 savings bond each, courtesy of The Anderson's Market, and hockey sticks signed by hockey great Gordie Howe, for themselves and their teacher.

"We are grateful for the donation of the signed hockey sticks," says Mary Croak, communications director for the Academy of Medicine of Toledo and Lucas County. The sticks are donated by academy member Murray Howe, MD, who brought Tar Wars to northwest Ohio seven years ago. Murray Howe, MD, happens to be Gordie's son.

The program, spearheaded by Dr. Howe, has since become projects for other cities as well. Cincinnati, Youngstown and Columbus also feature Tar Wars programs.

The Toledo Academy works in cooperation with the American Cancer Society, Children's Medical Center, and, of course, Anderson's, to deliver anti-tobacco messages to schoolchildren, with the hope that such direct contact will prevent youngsters from lighting their first cigarette.

"We have 130 volunteers who visit schools to talk about the dangers of smoking," says Croak. Most of these volunteers use either a slide show, available through the academy, or their own creativity, to talk to the children about the dangers of smoking, the benefit of a healthy lifestyle, and tobacco advertising that targets the young. Tar Wars is targeted to fifth graders, but the message can be made appropriate for any age group.

"This program has generated positive feedback from both our members and the community," says Executive Director Lee Walton.

In other words, a case of the original — just getting better. ■

Practice Tips



Patient Education

How credible is Internet health advice?

One study by Columbus pediatricians reveals that the quality of health-care advice your patients receive from the Web can vary a great deal – even when it's from a reliable source.

Increasingly, physicians are confronted with patients who have "done their homework" via the Internet. Perhaps because the research tool used is high-tech, patients perceive this information as cutting edge, up-to-date and accurate.

However, several pediatricians practicing at The Ohio State University College of Medicine and Public Health, and at Children's Hospital, Columbus, noted that the quality of the references presented to them by patients' parents seemed to vary.

About 18 months ago, H. Juhling McClung, MD, and two colleagues, OSMA member Leo A. Heitlinger, MD, and Robert D. Murray, MD, decided to conduct a study of Internet-site treatment advice for a common, well-defined condition – childhood diarrhea.

Study Methodology

The American Academy of Pediatrics (AAP) practice parameter on the management of acute gastroenteritis in young children was selected as the current standard by which other advice was judged. Compliance was judged quite loosely; that is, the information was judged to be in compliance if it promoted the use of oral rehydration with physiologic solutions that do not require complex compounding at home.

The study also afforded an opportunity to evaluate the awareness and compliance of the general medical community with the AAP guidelines.

Of the first 300 sites found through Internet search engines, only 60 quali-

fied as functional and nonduplicated, from traditional medical sources. Also, none of the information was designated "for adult treatment only."

The 60 qualifying sites were from the following sources: teaching centers, 20; news services, 13; practitioners, 10; health departments, 5; travel services, 5; textbooks, 3; HMOs, 3; professional societies, 1.

Site content was assessed for the following criteria: 1) as meeting AAP recommendations; 2) as being clearly for children; and 3) as meeting both criteria.

Study Results & Observations

Results were not reassuring. The content of only 12 sources (20%) met AAP recommendations. Twenty-eight sources (46%) were clearly for children.

Of those 28 articles referring to children, 12 (43%) met AAP guidelines. The source of the information, even if it were from a major academic medical center, did not improve the likelihood of compliance.

The study revealed that "medical information errors abound, even from traditional medical sources. Many documents report incorrectly the pathophysiology of infectious diarrhea and confuse the etiology of osmolar or toxicogenic diarrheas. Of greater concern were statements that are clearly in opposition to the body of responsible opinion, such as 'diarrhea is the body's method to eliminate undesirable elements,' 'diarrhea is caused by eating greasy junk food,' 'diarrhea is a cause of Reye's syndrome,' and 'restrict oral intake' during diarrhea."

From medical sources outside traditional medical centers came erroneous rehydration solution recipes, unusual drug recommendations involving antibiotics not approved for children's use, unconventional dietary guidelines restricting intake of specific foods

from fat and proteins to corn products and oatmeal.

Inappropriate recommendations from university-based teaching included: no distinction for the special needs of infants; several hours of fasting for infants with diarrhea; the use of decarbonated (high fructose) soft drinks; highly structured, ritualistic diets; and the use of sports beverages as rehydration solutions. Others contained a warning that aspirin exacerbates diarrhea, proposed the use of half-strength infant formula as a rehydrating fluid, or advocated adding a pinch of salt to the infant's intake.

Often within a single academic institution, various departments offered conflicting information.

"The lack of peer review and oversight of Web submissions was evident," concluded the authors. "While freedom from critical review may provide a rich and diverse cultural template, it can present bad medicine on an equal plane with good."

Information preparation dates were not available. Several documents were from clinic handouts, which have been free from critical review for decades.

The authors suggested that continued adherence to older treatment methods is probably a reflection that, in the United States at least, the outcome of acute diarrhea in children is almost uniformly favorable. Therefore, the wide variety of regimens used appear to be supported by the good outcomes of patients who receive them.

— Carol Larimer

Study Recommendations

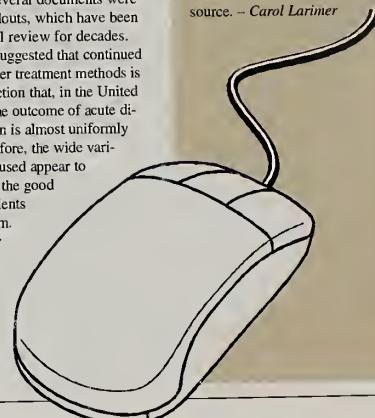
The study calls for responsible self-review and communication of your patient education material.

1. All medical practices should review and update handouts regularly.

2. Academic departments should regularly and rigorously monitor what their institutions present on their Internet sites.

3. The AAP should disseminate information from their position papers to the public as well as to practitioners. According to H. Juhling McClung, MD, since the publication of this study, the AAP site has been revised, and consumer information is much easier to access.

4. Practitioners need to warn their patients about the need for a very critical review of all medical information obtained from the Web, even when it seems to be from a "reliable" source. — Carol Larimer



Your Practice Guide

Take care to document DME need

The Office of the Inspector General has issued its latest fraud alert on durable medical equipment. Be certain you know Medicare's rules on DME before you order equipment for your patients.

The Inspector General of the Department of Health and Human Services recently issued a fraud alert expressing concern that physicians might order durable medical equipment (DME) without proper documentation.

For most health-care services, Medicare relies on the word of a physician to establish medical necessity. In the case of DME, however, Medicare requires that the physician confirm the need for services with a Certificate of Medical Necessity (CMN). A CMN has four sections:

- **Section A:** general information on the patient, supplier, and physician; may be completed by the supplier.
- **Section B:** medical necessity justification; must be completed by the

physician, a clinician who cares for the patient, or an employee of the physician.

- **Section C:** description and cost of the equipment; completed by the supplier.

- **Section D:** certification that the physician has reviewed the first three sections and that the information in Section B is complete and accurate; must be signed by the physician; signature and date stamps aren't acceptable.

"There seems to be an awful lot of concern about fraud and abuse in general," say Bill Fry, director, OSMA Department of Ombudsman Services. "Durable medical equipment is a very good example of how a physician can try to be a nice guy. A patient walks in and says, 'I think I need this chair that raises up.' The doctor might say, it's not going to hurt anything and signs the certificate."

continued on page 20

17 Ways to keep your laptop safe from thieves

Traveling with your laptop? During 1997, an estimated 309,000 cases of laptop theft occurred in the U.S. (an increase of 17% over 1996). Here's some advice to help you reduce the risk of theft.

Preventing theft:

- Carry your laptop in a cushioned bag that doesn't look like a laptop carrier;
- Don't become visually separated from your laptop at conveyor-belt security checkpoints for even a few seconds (the two-conspirator delay/grab/hide scam is the hottest one going);
- Don't place your laptop on top of your rollbag or luggage cart (the two-conspirator bump/distract/grab scam works here);
- Secure your laptop to a heavy piece of furniture in your hotel room or at a conference with special cables and locks.
- Protecting the laptop plus software:
 - Insure your laptop for replacement value;
 - Don't check your laptop in with your luggage. Your luggage may not arrive when you do and may

Laptop travel and security Web site resources

(OSMA does not endorse any listed products)

Safeware Insurance Agency: www.safeware-ins.com/losses97.html
Targus computer cases: <http://www.targus.com>
Anvil cases: www.anvildealer.com
Airport scams: <http://eaglenet.robins.af.mil/CIO/laptop.htm>
CompuLock: www.compu-lock.com/default.html
Qualice lock system: www.pcsecurity.com
SafeHouse encryption software: www.pc-dynamics.com/SafeHouse
Security/privacy screens: www.ergosupply.com/ergo.html
TrackIT transmitter alarm system: www.trackitcorp.com
CompuTrace Online Monitoring Service: www.computrace.com
U.S. Customs Service: www.customs.usitres.gov/travel/forms.htm
Products that support laptop use worldwide: www.laptoptravel.com
Info that supports laptop use worldwide: www.roadnews.com

become damaged. Checking laptops may also negate your laptop insurance.

Replacing the contents, such as that presentation you're giving at your destination - fast:

- Back up all contents onto a disk, and keep the disk on your person.

Preventing a thief from accessing the information in your laptop (depending on the sophistication and goals of the thief):

- Buy a laptop with a removable hard drive; don't keep it in the same bag as your laptop;
- Don't record your password anywhere in your case or hardware;
- Use software that automatically encrypts your input;
- Password-protect your screen-saver;
- Don't keep anything on your laptop that isn't germane to your trip, such as the password to your business' intranet (also known, in corporate espionage, as "bing-o").

Preventing your seatmate from reading what you're writing or studying:

- Use screen-shield software that exposes only the last few lines of copy.

Recovering your stolen laptop:

- Temporarily install in the laptop bag a *loud* alarm system that sounds when you and your laptop become separated by more than 40 feet;
- Etch your company's phone number on all hardware;
- Install hidden software that periodically calls a monitoring center that will trace the phone number the modem is dialing through.

And here's a bonus tip, to keep unnecessary expenses and hassles at bay:

Avoid paying duty on your U.S.-purchased laptop and peripherals when returning to the U.S.:

- Download the simple U.S. Customs Service Certificate of Registration, Form CF 4455, fill it out, and keep it with your laptop. — *Carol Larimer*

Your Practice Guide

Physician burnout

Rediscover your smile

Finding your funny bone in stressful situations may be the healthiest thing you'll do for yourself — and for your patients.

You don't have to be Patch Adams (the real-life doctor whose penchant for humor inspired the recent film of the same name) to know that the world needs more laughter.

"Humor, like creativity, are gifts we give ourselves," says Marie Carter Pollack, co-founder of Columbus-based Sensational Speakers. Pollack, aka "The Attitude Adjuster," speaks frequently on the subject of humor.

And in these days of managed care, stressed-out physicians and their patients need to remember the value of humor. "Why tighten up instead of lighten up?" Pollack asks. The fact is, a good belly laugh can lower your blood pressure, release endorphins, enhance respiration and circulation, and free your mind for creative problem solving — and who couldn't use more of that attribute in his or her practice? "Blessed are the flexible," says Pollack, "for they shall not be bent out of shape."

Learn to have fun

One's sense of humor is not predicated, as some believe, on being funny. "Only 20% of the population are capable of remembering and telling a joke," Pollack says. Instead, the

ability to look at the humorous side of things is about learning to have fun. "Humor and laughter don't just exist in the absence of sorrow and tears," she says. "They exist as a means to balance our sanity."

- In his book, *Lighten Up*, C.W. Metcalf provides three "human survival skills" essential to living:
1. The ability to see the absurd in certain situations.
 2. The ability to take yourself lightly while taking your work seriously.
 3. The ability to discover the sense of joy in simply being alive

"Humor prevents hardening of the attitudes," says Pollack. "It may not add years to your life, but it will add life to your years."

Smiles are good PR

And it may help your patients through a difficult time. "Think of yourself as the patient," Pollack suggests. You're in the examination room alone, frightened and not feeling well. A smile from you will help relax the patient and put him or her in the right frame of mind. "A smile is your PR department," she says. "Smiles add to your face value. Why do we save them? They're free, easy to do. Instead of 'grin and bear it,' I say 'grin and share it.' If

continued on page 20

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Your Practice Guide

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Document DME

continued from page 18

The IG's concern rests primarily on the possibility that physicians might unintentionally facilitate fraud against Medicare by simply signing forms presented to them by DME suppliers. The supplier completes the form and presents it to the physician, who, perhaps to be accommodating to the supplier or the patient, signs the form without verifying and documenting in the patient's medical chart the patient's need for the item. The physician may thus unwittingly sign a form that includes false or misleading information. If the physician knows the form to include false information, he or she risks penalties:

- criminal prosecution
- a fine of up to \$10,000 for each false claim plus treble damages
- administrative sanctions, including exclusion from federal health care programs and loss of license

A physician who receives compensation of any kind to sign the form is subject to additional anti-

kickback penalties.

"There are a lot of fraud and abuse initiatives that are taking place," Fry says. "But I consider this one important because it involves a doctor prescribing a product that is dispensed by another party. The other party's going to dispense that if the doctor says so, so therefore it behooves the doctor to make sure that he or she has adequate documentation in the patient chart to show the need for the equipment."

"Some doctor is going to say it's always medically necessary. Well, some doctors don't have documentation of it. It's important to have something in your chart that shows why that wheelchair or the crutches are needed." — Jan Leibovitz Alloy

Take action

For more information, contact Bill Fry, director, OSMA Department of Ombudsman Services, (800) 766-6762, Ext. 6760, or visit the fraud alert Web site, <http://www.dhhs.gov/progorg/aig/frdalart/index.htm>.

Smile

continued from page 19

someone doesn't have a smile, give them one of yours."

Your patients might also benefit from regular doses of humor in their lives. Laughter has healing power, as Norman Cousins points out in his book *Anatomy of an Illness*. Pollack puts it more succinctly, "Jest for the health of it," she says.

Humor, after all, is a way of looking at life. The more you look for it, the more you'll find — and the better you'll feel. Humor is a habit worth cultivating throughout your life. "Ethel Barrymore said it best, I think," says Pollack. "She said: 'You grow up when you have your first

good laugh at yourself.'"

That ability to laugh at yourself and at what life throws you, plus the capacity to reach down and touch that part of yourself that finds joy in living means, says Pollack, you have finally made it as a "humor being." ■

Take Action

If you are interested in learning more about incorporating humor in your life, you may contact Pollack at www.ohiospeakers.com/mpollack.html or contact The Humor Project, Inc., a national organization based in Saratoga Springs, New York. Their Web site is www.humorproject.com.

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Cleveland Academy

continued from page 4

charter and the terms of the mediation agreement AMC left the association with no option."

"If AMC were interested in true choice, we could have avoided this entire situation," Dr. Talmage said. "It could have voluntarily surrendered its charter with OSMA following the 1998 House of Delegates vote, then local physicians would be free to choose which organization they preferred to join."

Currently, the OSMA is responding to the lawsuit. Physicians who have questions about their memberships can contact the CCMS at (216) 861-0633 or the OSMA at (800) 766-6762. ■

Ohio Medicine

A Publication of the Ohio State Medical Association

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Ohio Medicine (ISSN 0892-2454/USPS 405-200) is published monthly for \$40 a year by the Ohio State Medical Association, 3401 Mill Run Drive, Hilliard, Ohio 43026. Periodicals postage paid at Hilliard, Ohio and at additional mailing offices. POSTMASTER: Please send address changes to Ohio Medicine, 3401 Mill Run Drive, Hilliard, Ohio 43026.

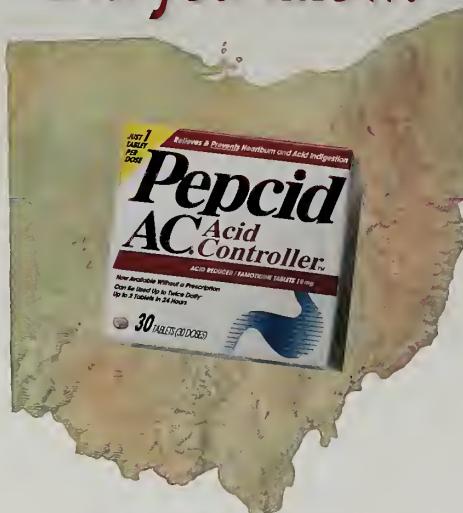
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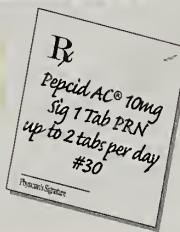
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1. IMS, 1998.
2. Decktor D, et al. A comparison of single-dose Pepcid AC vs. Prilosec 10 mg and 20 mg on human gastric acid secretion. American College of Gastroenterology 82nd Annual Scientific Meeting, Abstract, 1997.
3. 1998 Drug Topics®, Red Book Update.



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Colleagues



Newsmakers

RICHARD ABRAHAMSON, MD, and **STEWART KRUG, MD,** Cincinnati, played key roles in a recent *ESPN* documentary on boxer Aaron Pryor. Drs. Abrahamson and Krug performed surgery on Pryor's left eye to restore his vision that was damaged in a world championship fight in 1982.

MICHELLE ANDREWS, MD, Cincinnati, was selected by The American Academy of Orthopaedic Surgeons as the course chair for its Nursing and Allied Health Program in Year 2000. The course is designed to meet the needs of nursing and other allied health personnel associated with orthopaedic surgery.

THOMAS BOAT, MD, Cincinnati, director of Children's Hospital Research Foundation and chair of the Department of Pediatrics was recently appointed to the Board of Trustees at Children's Hospital Medical Center of Cincinnati.

GEORGE HALE, MD, Cincinnati, a founding member of Cancer Family Care was one of 10 "Lions" honored during its annual meeting and luncheon at the Hyatt Regency Hotel. Lions are senior community and civic leaders who have volunteered to benefit Greater Cincinnati.

D. ROSS IRONS, MD, Toledo, chief of surgery at Bellevue Hospital, received the Distinguished Citizen Award from the Medical College of Ohio at the 34th anniversary of its founding at the Founders' Day observance in December.



D. Ross Irons,
MD

RICHARD KAGAN, MD, Cincinnati, wrote two abstracts that won second and third place in the "Outstanding Poster Presentation" hosted by the American Association of Tissue Banks. The recog-

nition was made during the association's recent annual meeting. The papers focused on "The Use of Allograft Skin in Burn Care."

MYRON MOSKOWITZ, MD, Cincinnati, received the Award of Hope at the recent Survivors Luncheon sponsored by the Breast Cancer Alliance of Greater Cincinnati. Dr. Moskowitz is described by his colleagues as a "pioneer visionary" and the "Father of mammography." He established the Breast Imaging Center at the University of Cincinnati Medical Campus in 1973, and he was instrumental in developing the statistical justification of screening mammography.

RONALD J. TADDEO, MD, Willoughby, has been named by the Willoughby Area Chamber of Commerce as the Distinguished Citizen of the Year for 1999.

JOHN A. WINDER, MD, Toledo, was elected to a three-year term on the Board of Regents of the American College of Allergy, Asthma & Immunology (ACAAI). He also serves as chair of the Public Education Committee and the National Asthma Screening Program for the ACAAI.



John A. Winder,
MD

HECTOR WONG, MD, Cincinnati, was named director of critical care medicine at Children's Hospital Medical Center. Dr. Wong joined the staff of the Corryville hospital in 1995 as an expert in the care of infants and children with a variety of critical illnesses. ■



A presidential lineup... Past presidents of the Academy of Medicine of Toledo and Lucas County had strong representation at the Academy's 97th Annual Meeting, held Jan. 13. Those in attendance included: First row (left-right): William C. Sternfeld, MD; John H. Rabinson, MD; Lance A. Tolmage, MD (guest speaker and OSMA President); Gordon M. Todd, MD; John P. Anders, MD; and current president S. Amjad Hussain, MD. Second raw (l-r): Gerald W. Morsa, MD; Donald A. Marshall, DO; Su-Po Kong, MD; James G. Diller, MD; Lachman V. Chobhani, MD; John J. Newton, MD; Richard H. Koop, MD; and John C. Kellher, MD.

Obituaries

GEORGE W. BENNETT, MD, Elyria, Case Western Reserve University School of Medicine, Cleveland, 1942; age 81; died Jan. 30, 1999.

JAMES L. FARKAS, MD, Toledo, St. Louis University School of Medicine, St. Louis, 1952; age 73; died Feb. 16, 1999.

NORBERT GIZINSKI, MD, Brecksville, Hahnemann Medical College of Philadelphia, Philadelphia, 1943; age 81; died Feb. 19, 1999.

WILLIAM HUNT, MD, Columbus, Ohio State University College of Medicine, Columbus, OH, 1945; age 77; died Jan. 26, 1999.

RICHARD W. JUVANCIC SR., MD, Girard, University of Pennsylvania School of Medicine, Philadelphia, 1952; age 78; died Feb. 22, 1999.

ANTHONY KOKENAKIS, MD, Middletown, Faculty of Medicine National University of Athens, Athens, Greece, 1939; age 84; died Feb. 3, 1999.

JOHN J. NADAUD, DO, Toledo, University of Osteopathic Medicine & Health Sciences, Des Moines, IA, 1954; age 74; died Feb. 4, 1999.

JAMES E. SAMS, MD, Shadyside, Tulane University School of Medicine, New Orleans, 1937; age 85; died Jan. 30, 1999.

ROBERT W. VOLLMER, MD, Columbus, Ohio State University College of Medicine, Columbus, OH 1960; age 70; died Jan. 18, 1999.

REX K. WHITEMAN, MD, FACS, Warren, Indiana University School of Medicine, Indianapolis, 1942; age 81; died Feb. 9, 1999. ■

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A Publication of the Ohio State Medical Association

Ohio Medicine

Women's health initiative kicks off with osteoporosis education

The OSMA launches a two-year "Women's Health Initiative" project this month with educational materials on osteoporosis. Just in time for National Osteoporosis Month.

The OSMA launches its two-year Women's Health Initiative this month with its educational component on osteoporosis. Appropriately, May is National Osteoporosis Month.

The osteoporosis campaign is designed to educate primary care physicians on the importance of screening for osteoporosis and counseling patients regarding prevention. All OSMA members in selected primary care areas (family practice, general practice, ob-gyns) will receive

a packet of materials that includes the first in a series of handbooks developed by the AMA called *Managing Osteoporosis*. (Members will receive all three booklets as they are produced.)

In addition, the osteoporosis material will include Ohio-specific material as well as patient education material that can be reproduced and distributed to patients in your practice. ■

Take Action

If you do not receive the osteoporosis material by the end of May, contact the *Ohio Medicine* reader response line, (800) 766-6762, Ext. 6580 and ask for item #10-99.



Annual meeting features educational sessions

Resolutions won't be the only focus of this year's OSMA Annual Meeting. There will be an opportunity to learn more about physician compliance and pain management as well.

Resolutions covering legislative and reimbursement issues, as well as topics like alternative medicine and reinstating the state's certificate-of-need law, will occupy the attention of OSMA delegates and alternates this year, as they convene later this month (May 14-16) in Cincinnati for the association's annual meeting.

As of this writing, the OSMA House will consider 53 resolutions, as well as any Emergency Resolutions that are brought to it prior to the Opening Session on Saturday, May 15.

The installation of OSMA President-Elect David J. Utak, MD, Canton, as

OSMA president will take place Saturday morning, followed by committee hearings on each of the resolutions proposed. The House will conclude its business beginning 10 a.m. Sunday, May 16.

The Organized Medical Staff Section (OMSS) will hold its Annual Educational Forum on Friday, May 14. All OMSS representatives are urged to attend. Topics to be presented include "Physician Compliance" led by Bruce Blehart, JD, Office of the General Counsel of the AMA, and "The Critical Role of Physicians in Accountable Health-Care Organizations," led by William Monning, MD, secretary of the AMA-OMSS Governing Council.

OSMA members, delegates and al-

ternates are invited to attend a one-hour educational presentation on pain management Saturday morning, 8:30 a.m. to 9:30 a.m. Constantino Benedict, MD, a nationally-recognized expert on this issue, will lead a discussion based on responses to the survey included as part of *Pain — The Fifth Vital Sign*, the OSMA's handbook on chronic pain management. ■

Take Action

For more information on the OMSS Educational Forum, or to register, contact Shor Wockman, OSMA membership specialist, (800) 766-6762, Ext. 6773. For more information on the pain management presentation, or to register, contact the OSMA Department of Educational Services (800) 766-6762.

ugs dispensed from offices will need written instructions after June 1. Samples will need labels if they are prescribed for off-label use or if they are to be taken in a manner different from that found in packaged inserts.



4
new fraud and abuse data bank will alert users when a comprehensive review of a physician's practice may be prudent. Users will include government agencies and health-care plans.

9
lternative therapies are becoming more mainstream as patients look to new health-care approaches in increasing numbers. The best thing you can do is to talk to your clients about these treatments.

11
law requires you to report your change of address to the State Medical Board of Ohio each time you relocate, according to evidence compiled by the OSMA, which is not always being done.



itemized billing statements must now be given to Medicare patients who request them. If you don't regularly create itemized statements, here are recommendations on what to include.

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Bills, Laws & Rules



Drugs dispensed from office will need written instructions after June 1

New labeling rules from the Ohio Board of Pharmacy will mean every medication that leaves your office with a patient needs to contain certain information.

New labeling rules for office dispensing have been finalized by the Ohio Board of Pharmacy and are due to take effect on June 1. This article attempts to address some of the concerns that have been expressed already by the medical community. Sources for this article include: Nancy Gillette, JD, OSMA Division of Legal Affairs; Marla Bump, OSMA Department of Legislation; Andrew Corsig, regional director, Pharmaceutical Research and Manufacturers Association (PRMA); Dan Leite, government affairs, PRMA; and Tim Benedict, assistant executive director, Ohio Board of Pharmacy.

Q: Do all prescription drugs dispensed from my office now have to be labeled?

A: Yes. Prior to the labeling rule, the only medications dispensed from your office that required labels were controlled substances. The new rules expand the labeling mandate to all prescription drugs except samples. There are, however, specific rules for samples. (See question below.)

Q: What information must be placed on the label?

A: Each label must include the following information: 1.) the name and address of the prescriber; 2.) the name of the patient; 3.) the date the drug is dispensed; and 4.) the directions for use.

Q: Will pharmaceutical companies provide me with these labels?

A: No. You will have to procure the labels yourself, and place on them the information that is required. These labels can be preprinted and affixed to the container. Directions for use must be in a written format, but do not have to be in the physician's handwriting, nor signed by the physician. The directions may be printed on a separate sheet of paper.

Q: Do I have to label the drug samples I dispense to patients?

A: That depends. If you are using the drug as a treatment for something other than its recommended use (off-label use), yes. You will have to provide the patient with the same information that is required of all drugs leaving your office. That's true, as well, if you direct the patient to use the drug in a manner that is different from the directions printed on the prepackaged insert, or the information contained on the sample container. However, if you have instructed your patient to use the sample according to its use and the preprinted directions, the sample does not have to be labeled.

Q: The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) can send inspectors into hospital-owned physician practices. These inspectors have their own requirements for dispensing and labeling drugs, as well as sample handling. What happens if the

JCAHO standards conflict with the pharmacy board's drug rules?

A: The JCAHO is an accrediting body, not a statutory body. It cannot make laws or rules for Ohio physicians. Physicians who are in hospital-owned practices should follow Ohio's new labeling laws. JCAHO protocols cannot supersede state law. If you do run into such conflicts with JCAHO inspectors, notify the OSMA Department of Legislation or the Ohio Board of Pharmacy. These field experiences will be collected and reported to the Legislature so that the law and/or rules can be clarified if necessary to avoid future conflicts.

Q: Do the rules prohibit a pharmaceutical representative from accessing my sample closet and re-stocking?

A: No, not expressly. However, the rules do discourage any individual, not just pharmaceutical representatives, from having unsupervised or unmonitored access to a physician's sample closet.

Q: If I write a prescription for a drug, and also send samples of the drug home with the patient, will the prescription suffice in meeting the labeling rules?

A: If the prescription is written in lay terms and filled after the samples have been used, then yes, the required information will be in place for the patient. However, do not expect a patient to read a prescription that has been written using the familiar Latin terms.

Why the new labeling laws?

The Ohio Board of Pharmacy wants to ensure that all patients who are dispensed medications leave the facility with specific directions for use. In some cases, the patient is sent home with a white envelope of pills, and either doesn't know the instructions for use, or forgets the instructions the doctor related while handing over the pills. Hundreds of people are admitted to the hospital each year because they do not take their medications properly. A quick poll of about a dozen OSMA members found that most physicians don't have any problem with the rules' purpose. They agree with the pharmacy board that this is a patient safety issue. Further, the rules grew out of Senate Bill 66, now law, which includes a provision stating that physicians must furnish proper instructions with the medications they dispense.

Take Action

If you have further questions about the labeling rules that are not addressed in this article, you may contact the Ohio Board of Pharmacy, (614) 466-4143 or Nancy Gillette, OSMA Division of Legal Affairs, (800) 766-6762, Ext. 6767.

AMA has concerns about new data bank

The OIG's proposed rules are too broad, says the AMA. Among other things, the term "health plan" must be narrowed.

When the Office of the Inspector General (OIG) proposed the rules for its Healthcare Integrity and Protection Data Bank (HIPDB) and opened them up for comment, the AMA stepped up to the plate with a number of written concerns. Some of them are listed here:

- The regulation must clearly indicate that billing errors will not be reported.
- The definition of "health-care fraud and abuse," as stated in the preamble, is too broad and must be narrowed.
- The definition for "health plan," as outlined in the rule, is too expansive. It opens the data bank to any party that acts as a third-party payor. The term "health plan" must be narrowed.
- Adverse clinical privileges should not be included among those actions reported to the HIPDB.
- The amount of information to be reported to the HIPDB is meaningless and should be reduced.

"Basically, the AMA's objections have to do with the fact that the OIG's proposed rules are just too broad," says Nancy Gillette, JD, in the OSMA Division of Legal Affairs.

So far, the AMA has not received a response from the OIG, nor has an effective date been established for the rules. Therefore, the data bank is not yet operational. Continue to watch *Ohio Medicine* for further developments concerning the HIPDB.

Fraud and abuse The national fraud and abuse data bank: One more physician watchdog

The new Healthcare Integrity and Protection Data Bank will serve as a flagging system for health plans and others making decisions about practitioners.

The fraud and abuse data bank, proposed by the U.S. Department of Health and Human Services' Office of the Inspector General, isn't going to go away. Its creation, in fact, has been stipulated by the Health Insurance Portability and Accountability Act of 1996. Although the rules have been proposed, and a comment period completed, (see related story for the AMA's concerns about the data bank) there is no indication, yet, when the database will be up and running. You may want to become familiar, however, with the new data bank's parameters. Here is what you need to know about the database...officially known as the Healthcare Integrity and Protection Data Bank (HIPDB). Where health-care practitioner is mentioned, the term applies also to health-care providers and suppliers.

What is the purpose of the HIPDB?

The HIPDB will be a national health-care fraud and abuse data collection program for the reporting and disclosure of certain final adverse actions taken against health-care practitioners.

Its primary purpose will be to serve as a flagging system, alerting users that a comprehensive review of the practitioner may be prudent. The information, like the National Practitioner Data Bank, is to be used by sources in making determinations on employment, affiliation, certification or licensure decisions.

What kind of information will it contain?

1.) Civil judgments against a health-care practitioner in federal or state courts, related to the delivery of a health-care item or service; 2.) federal or state criminal convictions against a health-care practitioner related to the delivery of a health-care item or service; 3.) actions by federal or state agencies responsible for the licensing and certification of health-care practitioners; 4.) exclusion of a health-care practitioner from participation in federal or state health-care programs; and 5.) any other adjudicated actions or decisions established by regulations.

Who will have access to the information?

The information will be available to federal and state government agencies (including Medicare carriers that contract with the government), health plans, and any health-care practitioner who requests information about himself, herself or itself. HIPDB information, however, will not be available to the general public. However, per-

sons or entities will be able to request information in a form that does not identify any particular practitioner.

Can information reported to the HIPDB be challenged?

The subject of a report may dispute only the factual accuracy of the information, and not issues regarding the merits of the case, or the due process that the subject received. The dispute process will afford the subject an opportunity to bring relevant factual information, including reversals of criminal convictions by an appeals court, to the attention of the reporter. If the reporter does not revise the information within 30 calendar days, the subject can request that the matter be reviewed. After review, information will be corrected, left unchanged, or amended as appropriate.

Watch *Ohio Medicine* for further developments on this story. ■

Take Action

Information for this article come from the Health Resources and Services Administration Web site. You can learn more about the proposed Healthcare Integrity and Protection Data Bank by visiting the site, www.hrsa.dhhs.gov/bhpr/dqa/hipmain.htm. If you have questions about the information presented here, contact Nancy Gillette, JD, OSMA Division of Legal Affairs, (800) 766-6762, Ext. 6767.

Rule change broadens NPDB scope

Payers would be required to report the practitioner whose actions led to a claims payment, even if the practitioner is not a defendant in the lawsuit, if a proposed rule change to the National Practitioner Data Bank (NPDB) is adopted.

The rule is an effort to close a loophole allowing physicians to circumvent reporting requirements if only a hospital, group practice or other corporate entity is named as a defendant.

The comment period has ended, but not before the AMA filed a letter that called the proposal "ill-advised" and said it raises "serious due process questions and places an unfair burden on physicians and other practitioners who aren't parties to an action or claim."

Final rules aren't due until the end of the year.

No more free data from NPDB... Want to check your records in the National Practitioner Data Bank? Prepare to pay a fee. A new rule, effective March 1 and proposed by the Department of Health and Human Services, removes the prohibition against charging for self-queries. ■

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New Healthcare Legislation

The following bills have been introduced since the deadline for the April issue. Where appropriate, on OSMA staff member and extension number is listed for those who would like more information about the bill. Call (800) 766-6762 and ask for the extension you need.

Senate Bills

Senate Bill 80. Mastectomy procedures
If passed, SB 80 would require most payors to provide coverage for a second opinion following a recommendation for a mastectomy; for the amount of inpatient care following the mastectomy that's recommended by the treating physician; for breast reconstructive surgery; and for physician-directed follow-up care related to the mastectomy.

Sponsor: Sen. Anthony Latell, Jr. (D-Girard)

OSMA contact: Nick Lashutka, Ext. 6747

OSMA position: Neutral with technical assistance

Senate Bill 99. Prescriptive authority

This is the bill the Advanced Practice Nurses have been bringing to the Statehouse for a number of years. If passed, SB 99 (along with its companion bill, House Bill 241) would permit certified registered nurse anesthetists, clinical nurse specialists, certified nurse-midwives and certified nurse practitioners to prescribe drugs and therapeutic devices.

Sponsor: Sen. Merle Kearns (R-Springfield)

OSMA contact: Marla Bump, Ext. 6741

OSMA position: Opposition

Senate Bill 102. Human cloning

This legislation would prohibit the cloning of a human being.

Sponsor: Sen. Roy Ray (R-Bath)

OSMA contact: Marla Bump, Ext. 6741

OSMA position: Support with technical assistance

Senate Concurrent Resolution 7.

Health-care torts

SCR 7 expresses the Ohio General Assembly's opposition to the expansion of tort liability in the health-care system.

Sponsor: Sen. Lynn Wachtmann (R-Napoleon)

OSMA contact: Tim Maglione, Ext. 6746

OSMA position: not yet considered

Senate Concurrent Resolution 9.

Obesity awareness

If adopted, SCR 9 would designate the month of July 1999 as "Obesity Awareness Month." It also urges the Ohio Department of Health and the medical community to combat obesity.

Sponsor: Sen. Grace Drake (R-Solon)

OSMA contact: Krista Bistline, Ext. 6748

OSMA position: Neutral

House Bills

House Bill 200. Student immunizations

This bill would suspend the requirement that a pupil who begins kindergarten during or after the school year beginning in 1999 be immunized by a Department of Health-approved method of immunization against hepatitis B, the requirement that local governments and boards of health provide the means of immunizations against hepatitis B, and the authority of the department to approve means of immunization against hepatitis B.

Sponsor: Rep. Dale Van Vyven (R-Sharonville)

OSMA contact: Marla Bump, Ext. 6741

OSMA position: Active opposition

House Bill 205. Tort immunity

HB 205 amends the definition of "governmental function" in the political subdivision tort immunity law to include the operation of all types of aquatic facilities.

Sponsor: Rep. Bob Corbin (R-Centerville)

OSMA contact: Tim Maglione, Ext. 6746

OSMA position: not yet considered

House Bill 210. Medical Savings

Accounts

If passed, HB 210 would require certain private-sector employers to open a medical savings account on behalf of an employee upon the employee's request.

Sponsor: Rep. Bob Netley (R-Laura)

OSMA contact: Nick Lashutka, Ext. 6747

OSMA position: Support

House Bill 218. Infant Formula

HB 218 makes infant formula, prescribed by a participating provider, a basic health-care service that should be covered by HMOs.

Sponsor: Rep. Gene Krebs (R-Camden)

OSMA contact: Nick Lashutka, Ext. 6747

OSMA position: Neutral

House Bill 239. Tobacco Settlement

This bill establishes the Tobacco Settlement Task Force for distribution of the tobacco fund settlement monies to be received by Ohio.

Sponsor: Rep. Ray Miller (D-Columbus)

OSMA contact: Marla Bump, Ext. 6741

OSMA position: Support

House Bill 241. Prescriptive authority

This is the bill that Advanced Practice Nurses have brought to the Statehouse for a number of years. If passed, HB 241 (and its companion bill, Senate Bill 99) would permit certified registered nurse anesthetists, clinical nurse specialists, certified nurse-midwives, and certified nurse practitioners to prescribe drugs and therapeutic devices for patients.

Sponsor: Rep. Nancy Hollister (R-Marietta)

OSMA contact: Marla Bump, Ext. 6741

OSMA position: Opposition

House Bill 253. Medical records fees

HB 253 specifies the fee that health-care providers and HMOs may charge for providing medical records. It also provides that a medical records company must be formed as a domestic

corporation and specifies that a medical records company is subject to regulation by the Department of Commerce.

Sponsor: Rep. Otto Beatty (D-Columbus)

OSMA contact: Marla Bump, Ext. 6741

OSMA position: Opposition

House Bill 261. Qualified immunity

This bill repeals the scheduled repeal of the laws that establish qualified immunity from civil liability for health-care providers who provide free health-care services to indigent and uninsured persons.

Sponsor: Rep. Twyla Roman (R-Akron)

OSMA contact: Marla Bump, Ext. 6741

OSMA position: Active support

House Bill 272. Osteoporosis

HB 272 requires all HMO policies, contracts and agreements, sickness and accident insurance policies and public employee benefit plans to provide coverage for services related to the diagnosis, treatment and appropriate management of osteoporosis.

Sponsor: Rep. Samuel Britton, (D-Cincinnati)

OSMA contact: Nick Lashutka, Ext. 6747

OSMA position: Under advisement

House Concurrent Resolution 11. Tobacco settlement

HCR 11 asks the Congress to oppose efforts by the federal government to recoup its smoking-related expenditures under the Medicaid program from the money the states are to receive from the tobacco settlement.

Sponsor: Rep. James Jordan (R-Urbana)

House Concurrent Resolution 12. Insurer Y2K problems

HCR 12 provides that the General Assembly finds it in the public interest to give legislative consideration to the goal of allowing insurers to concentrate their resources to address any Year 2000 problems, particularly between July 1, 1999 and June 30, 2000 to the extent that rights of policyholders are protected.

Sponsor: Rep. Dale Van Vyven (R-Sharonville)

OSMA contact: Nick Lashutka, Ext. 6747



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Med board wants attorney general's opinion on "medical necessity" decisions

The medical board has asked the state attorney general if it has the right to act on complaints in which an Ohio-licensed physician has rendered an opinion of "medical necessity."

The State Medical Board of Ohio has questions about the rendering of "medical necessity" decisions by licensed Ohio physicians—and it has put its questions to State Attorney General Betty Montgomery.

Specifically, the board wants to know:

- Does the rendering of an opinion of "medical necessity" constitute the practice of medicine when the opinion is offered for purposes of utilization review?

- Does the medical board have the authority to act when it receives a complaint alleging that the physician violated "Medical Practices Act" in formulating or offering that opinion?

The medical board receives complaints based on both of the above, but is uncertain whether or not it has the authority to review and act on the complaints.

The OSMA, however, believes that the board is within its rights to do so, and has sent a letter to Attorney General Montgomery stating why:

"Regardless of a physician's professional position, every Ohio-licensed physician must be held to the same licensure and disciplinary standards when they engage in conduct that is the equivalent of advising or recommending treatment," the OSMA letter states. "There is no basis upon which to differentiate among physicians in active practice or physicians who serve in other capacities when they engage in functionally similar medical decision-making processes. Any individual who is using knowledge and skills learned as a result of education and training in medicine to make decisions advising or recommending treatment of an individual patient in Ohio, including medical necessity determinations or decisions regarding appropriateness of treatment, should be licensed by and subject to discipline by the State Medical Board. More simply put, persons who make medical decisions should be accountable to the medical board."

There is no indication when a reply

Medical Board Report

might be expected from the attorney general's office. *Ohio Medicine* will keep you posted.

Of note...

Will board monitor trainees?...As the medical board prepares to implement House Bill 606, the law requiring residents and clinical fellows to have training certificates, there is a question as to how closely the board should monitor residents. If a complaint is filed against a resident, the board would have to investigate it. But the AMA as well as some board members are opposed to allowing medical boards to take disciplinary actions against residents. Instead, program directors should have the major responsibility for monitoring residents and the board should get involved only if patient care is affected. Most program directors dismiss residents who do not do well in training programs. The board is aware that its monitoring of residents needs to be handled in a manner that does not pose unnecessary problems for training programs. Discussions on this issue continue to be held at the board committee level.

Pain advisory committee established... The board voted to establish an Ad Hoc Pain Advisory Committee on the recommendation of its Pain Management Committee. Thomas Gretter, MD, Cleveland, will chair the new ad hoc group. The pain advisory committee will direct the board as it wrestles with problems brought to it by physicians working under the board's new pain management rules. The ad hoc committee will be limited to five people. The board's pain management committee has also sent a letter to the OSMA, complimenting the association on the quality of its publication, *Pain – The Fifth Vital Sign*. (See story at right.) ■

Bills that need your attention

Contact your state representative or senator by phone, fax or e-mail, and voice your support or opposition to these important health-care bills. To find your representative or senator, visit the OSMA Web site, www.osma.org, go to the "Links page" and look for "Government/State" section and click on "Ohio General Assembly." Or call the OSMA Department of Legislation, (800) 766-6762.

House Bill 4. Patient Protection Act

Supported by Gov. Bob Taft and the OSMA, HB 4 holds HMOs accountable for the health-care decisions they make when those decisions result in adverse outcomes. Call your representative now and voice your support of this bill.

OSMA position: Active support

House Bill 138.

Statewide trauma system

Like its predecessor last session, HB 138 would establish a statewide trauma system in Ohio, but some changes have been made. This time, hospitals could be verified as trauma centers by either the American College of Surgeons or the Ohio Department of Health. Other changes were made that took into consideration OSMA recommendations. The bill is still in the House. Call your representative and tell him or her you support HB 138.

OSMA position: Support

House Bill 200.

Student immunizations

HB 200 threatens what most doctors in the medical community perceive as a good idea — that all students be im-

munized against hepatitis B by kindergarten. The immunizations were mandated by a law that passed last year, but opposition groups to the immunizations have been vocal. Consequently, HB 200 was introduced to suspend the requirement. The OSMA Committee on State Legislation voted to actively oppose this bill, and it's worth noting that the Centers for Disease Control, the American Medical Association, and the American Academy of Pediatrics all support immunizing infants against the highly-contagious hepatitis B. Contact your representative and tell him or her to oppose HB 200.

OSMA position: Active opposition

House Bill 241. Prescriptive authority

This bill is also in the Senate as Senate Bill 99. Both bills would permit certified registered nurse anesthetists, clinical nurse specialists, certified nurse-midwives, and certified nurse practitioners to prescribe drugs and therapeutic devices for patients. The Advanced Practice Nurses have brought this bill to the Statehouse before, and their political clout is growing. In order to defeat the bill again, it's important that you educate your state representative or senator on the difference in education between physicians and nurses, and that you express your opposition to this bill now.

OSMA position: Opposition

Physician Legislative Action Network is a grassroots organization of physicians who support and sometimes oppose health-care legislation by contacting their legislators and presenting the views of organized medicine. For more information, or to join, contact Krista Bistline, OSMA Department of Legislation, (800) 766-6762, Ext. 6748

Med board commends OSMA's pain handbook

The OSMA received the following letter from the State Medical Board of Ohio.

Dear (OSMA):

As chair of the Medical Board's Pain Management Committee, I'd like to extend my commendations to you and all of those who worked so hard to compile *Pain – The Fifth Vital Sign*. This concise publication will aid practitioners in their treatment of

patients with complex pain problems. Additionally, I hope that most of Ohio's physicians take advantage of the continuing medical education hours available with this publication. Thank you for your efforts.

Sincerely yours,

C. Denny Stienecker, MD
Chair, Pain Management Committee
State Medical Board of Ohio

Indepth Report

Alternative medicine

Talk to patients about alternative therapies

A study in the Nov. 11, 1998 edition of the *Journal of the American Medical Association* says Americans visit alternative medicine practitioners more often than primary care physicians.

Decades of research has shown Premarin to be effective in the four disease states of meno-pause — osteoporosis, Alzheimer's disease, cardiovascular disease, and colorectal cancer. "It's truly been a godsend" for postmenopausal women, says Frank E. Isabelle, MD, of Columbus. But for the past four years, Dr. Isabelle has offered patients another option, "bioidentical" hormones derived from the Mexican yam and soy plant. The alternative therapy, because it has fewer side effects, is more acceptable to some patients. Until they began to ask for it, Dr. Isabelle didn't know the alternative therapy existed. Now as a patient approaches perimenopause, he tells her the pros and cons of the complementary therapy, as he prefers to term it, along with those of the more traditional choices.

Researched before prescribed

Dr. Isabelle, former chair of the ob-gyn department at Grant Medical Center, researched the bioidentical hormone therapy thoroughly before he began to prescribe it. But patients also ask for therapies, such as acupuncture and herbal remedies, that he is less familiar with. "I don't have any problem with a patient of mine trying something," he says. "If she said to me, 'I have cancer of the uterus; I'm going to use acupuncture to get rid of it,' I would probably discourage that. But if she said, 'I have this pain and the traditional pain center hasn't seemed to help me,' then I'd say, 'Acupuncture might be

something you want to investigate.'"

The term "natural" seems to have an allure for patients, says Colette Willins, MD, of Westlake. "I tell them hemlock is all natural but it's poison," she says. "I'm not against medications from natural sources, I'm just for medications that have been adequately tested for safety and efficacy. If they think that St. John's wort might help with depression, further studies need to be done to figure out what components of that plant are actually giving the benefit, how much is enough, how much is too much, and what other drugs it interacts with."

Educate patients

Like Dr. Isabelle, when asked about a particular alternative therapy Dr. Willins discusses what she knows so her patient can make an informed decision. "Does it cause some other harm? Might it be complementary to other things you do? If you've got something that might not work but you know is safe, then using it along with something that's traditional probably is OK." On the other hand, she tries to discourage a patient who might want to drop a current therapy that's working in favor of an untested alternative. "Usually when you phrase it, 'I'm worried about you; I want what is best for you; you are an adult but I'm just trying to educate you,' then most of them say, 'I don't think it's worth trying.'"

Compassionate rapport

The alternative therapy provider might be an acupuncturist, an herbalist, or a massage therapist. Then again, it might be a licensed physician. Henry F. Kenkel, MD, a neurologist and psychiatrist, is director of the Franciscan Wholistic Health Center. The staff of the clinic, on the campus of Franciscan Hospital in Mount Airy, includes psychologists, a nurse practitioner, and teachers of yoga, t'ai chi, and Felden-

kras and movement therapies. "It's a mind/body/spirit approach," Dr. Kenkel says. Patients who come to the clinic "may have been through a fairly substantial medial odyssey where they've had extensive workups and treatment that might not have helped, and they want to try something else. I look at what about them personally is impacting upon their illness. They go through many, many, many investigations and formulations, but they may never have been talked to about the emotional factors that affect illness."

The holistic approach is intended to support allopathic medicine, Dr. Kenkel says. "We won't treat anybody here who doesn't have a relationship with a primary doctor. We don't replace that."

Much of the approach is based in developing a compassionate rapport with the patient, the kind of relationship that all doctors strive for but that becomes more and more difficult under managed-care systems.

Compassionate rapport is the bottom line regardless of the treatment choice a patient makes. "If a patient needs surgery and wants the option of trying not surgery," Dr. Isabelle advises, "say, 'Fine, let's work with that.' If you start off by saying, 'Well, we'll try it, but I don't think it's going to work, I think you're eventually going to come to surgery,' you've defeated her. If you say, 'Let's see how this works, let's just diligently stick to the plan we developed,' if it comes out to surgery she's far happier because she gave it to the best shot and had the support of someone in her decision." —Jan Leibovitz Alloy

Take Action

For more information about talking to your patient about alternative therapies, contact Frank E. Isabelle, MD, (614) 326-1000; Henry F. Kenkel, MD, (513) 853-5992; or Colette Willins, MD, (440) 304-0119.

11 steps to take if your patient requests alternative therapy

In the *Annals of Internal Medicine*, Daniel M. Eisenberg, MD, suggests an approach for working with a patient who chooses to visit an alternative therapy practitioner.

1. The patient should have a complete medical evaluation, including a referral to consultants, if indicated.
2. Tell the patient of conventional therapeutic options; the patient may try or refuse those options. Then the following process might be considered:
3. Ask the patient to identify the principal symptom.
4. Maintain a symptom diary.
5. Discuss the patient's preferences and expectations.
6. Review issues of safety and efficacy.
7. Identify a suitable licensed provider.
8. Provide key questions for the alternative therapy provider during initial consultation.
9. Schedule a follow-up visit (or telephone call) to review treatment plan.
10. Follow up to review the response to treatment.
11. Provide documentation.

PDR for Herbal Medicines

Medical Economics, publisher of the *Physicians' Desk Reference* (PDR), also publishes a directory of herbal medicines. The *PDR for Herbal Medicines* has more than 600 entries.

Take Action

PDR for Herbal Medicines costs \$59.95 and is available from the publisher. Call, (800) 678-5689 to order a copy.

Protection or Poison?



Things are not always as innocent as they seem. What physicians and surgeons once trusted as the most basic of safety precautions has frequently turned into a life-altering threat. Victims of Type I Latex poisoning daily face dangerous exposure from such seemingly harmless sources as a child's toy balloon. This can result in devastating career and lifestyle changes — and in some instances, even death!

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OSMA News

Where have all the doctors gone?

Keeping up-to-date on physician moves can be challenging for the State Medical Board of Ohio (and the OSMA). Yet doctors are required by law to inform the board of their every relocation.

If your principle practice address, or residence address of record has changed, did you know that you are required by law to notify the State Medical Board of Ohio, in writing, within 30 days of the move?

Apparently, this isn't happening — as evidenced by the number of pain handbooks (*Pain — The Fifth Vital Sign*) returned to the OSMA by the post office. The OSMA had used a mailing list from the medical board to mail out its pain handbooks to all licensed Ohio physicians. But a full 10% of the 28,000 handbooks mailed in February have returned to OSMA offices. Many have been re-mailed to the correct address, provided by the post office and physicians who have called — yet hundreds of booklets still wait re-routing.

The mailing list, incidentally, was relatively current. Because of the new licensure schedule, the oldest license renewal records were only two years old.

Change is your responsibility
While the OSMA is making diligent efforts to locate physicians whose pain handbooks were returned, the issue of change of address is an important one — especially where the medical board is concerned, for the board is prohibited by statute from changing addresses in their records without written notice from the physician's office. In other words, just because the medical board has re-sent your licensure packet to you because the post office sent it back with a forwarding address, don't assume that the medical board has made the address change in

your records. Notifying the board of your change of address is your responsibility. And the principle practice address must be entered at each renewal.

With 30,000 licensed physician records to maintain, the board received 145 address changes from physicians in January and 210 in February. These changes were not in response to any particular mailing. Of about 15,000 records, OSMA receives between 200-300 changes each month, with a peak at the end of the medical school year.

Where do they go?

Debra L. Jones, the medical board's chief of CME records and renewals, says "Most address changes occur when physicians move from residency or fellowship positions into new employment, retire, or move to another state or outside the U.S."

"Nationwide, physicians are also moving to areas less affected by managed care," says Doug Evans, OSMA Director of Membership Services. "And we're seeing a tremendous number of physicians changing their mode of practice, particularly toward group practices."

In fact, preliminary figures from a recent OSMA group practice survey indicate that a large percentage of group practice physicians are changing addresses at any given time.

No penalties yet

Right now, no direct penalty exists for noncompliance with address-change notification to the State Medical Board, nor is one expected in the near future. However, direct and indirect costs exist — to physicians and other taxpayers — through returned mail and re-mailing postage, additional staff time, shortened available response time to mailings, and nondelivery of critical information.

The bottom line is that moving, no matter where, is an inconvenience —



Address Change needed... Hundreds of pain handbooks have been returned to the OSMA because of incorrect addresses.

but that move may be a great deal more inconvenient than you planned if you are missing important material, not only from the OSMA, but from your state licensing board. As soon as possible after your move, prepare your change of address cards and send them out — and please make sure that the medical board and the OSMA are on your mailing list. — Carol Larimer

Take Action

When your new employment or address plans are final, be sure to notify the State Medical Board of Ohio and the OSMA that you have moved.

Here's how:

State Medical Board of Ohio: Send a signed change-of-address postcard or a letter on your old or new letterhead to: Records Dept., State Medical Board of Ohio, 77 S. High Street, 17th Floor, Columbus, OH 43266-0315.

OSMA: Contact Membership Services, (800) 766-6762, or e-mail: members@osmo.org. You may also write the OSMA at 3401 Mill Run Dr., Hilliard, OH 43026.

More physicians earn CME locally

Ohio physicians are staying home to get their CME credits, says a study conducted recently by the OSMA's Continuing Education and Outcomes Research Department. Although about half the respondents' CME is still earned outside the state, a significant number of physicians are finding the convenience, quality and cost of in-state opportunities influence their choices. Results show that about 10% of respondents now receive all their CME in Ohio, while only 2% go outside the state for all of their CME credit.

This finding speaks well for the OSMA, which is Ohio's only accrediting body for CME sponsorship. One of the OSMA's missions is to assure ample, high-quality CME opportunities in all areas of the state. Nearly two-thirds of the respondents were aware of OSMA's vital role in accrediting organizations — such as hospitals, group practices, specialty societies and other organizations — to provide quality CME. And 75% of the respondents felt that the OSMA's role in CME continues to be a very important service for physicians.

Other survey results show:

- Choice of CME is influenced most often by subject/speaker, followed by time/availability, location, cost, and hours of credit.

- Live presentations are the most frequent way to collect CME credit. That's followed by home study, audiocassettes and printed media, televised CME and videocassettes.

- Mandated CME is not popular. According to those who answered the survey, 67% thought it was very important for the OSMA to continue to fight regarding this issue; 21% thought it somewhat important; 9% were neutral; and 3% thought it not at all important. — Yvonne H. Burry

Take Action

If you wish to comment on CME issues, please e-mail the OSMA at cme-outcomes@osmo.org.

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President's Perspectives

Advocacy is my legacy

I believe that one of organized medicine's greatest strengths — and one of the greatest benefits to you, personally — lies in our role as advocates for the profession.



Lance Jollmogen, MD

It's a role that takes place at all levels of the federation — from the American Medical Association to the OSMA to your own county medical society.

Whether the issue is the unfair scrutiny of our profession for fraud and abuse, or the need for prompter payments from insurers, organized medicine works on a united front to address the concern and seek resolution.

The "AMA Report" that runs monthly in *Ohio Medicine* provides you with updates on advocacy issues that are tackled on a regular basis by the AMA. In March, Andrew Thomas, MD, the resident representative on the AMA's Board of Trustees wrote about the "Little Things that Add Up" to a major advocacy role for the AMA — including lobbying against a Medicare provider fee and successfully causing the Health and Human Services department to scale back and refocus its PATH audit program. And last month, AMA Board of Trustee member, Herman Abramowitz, MD, told you how the AMA responded to proposed fraud and abuse rules by sending a letter to the Office of the Inspector General, requesting that the rules be made more clear, and that they be fairly enforced.

The OSMA serves as your advocate as well, offering its members a contract review service and an ombudsman department to assist you with third-party payor problems. We also take an aggressive legislative stance on those health-care bills that threaten the practice of medicine, and we advocate for

continued on next page

the profession and our patients.

Your county medical society takes on the role of advocacy, too — sometimes with projects specific to your area (boosting autopsy rates in Franklin County, for example), other times a local slant is provided on a broad, national issue (like Montgomery County's managed-care committee, composed of physicians, osteopaths and local attorneys.)

As I prepare to step down from the office of OSMA president this month, I assure you that I will not retire from my role as advocate for medicine. I have been appointed to the State Medical Board of Ohio. In this position, I will bring my commitment of physician advocacy to the board. The board's responsibility lies both in serving and protecting members of the public — and in serving the state's physicians. I will try to ensure that physicians are treated justly but fairly and humanely by the board — in all of its dealings with our profession — as it strives to eliminate inappropriate and illegal practices and practitioners from Ohio's health-care delivery system, and to ensure the best health care for our patients.

As your president, I hope that I have made a difference in assuring the time-honored dignity and respect of our profession. I trust that physician advocacy is a legacy that will continue to serve as the basis of the OSMA and other members of the federation of medicine. And I promise you it's a legacy I intend to continue — in whatever role I may serve. ■

BECAUSE THIS IS NO PLACE
FOR A DOCTOR TO OPERATE.

Talmage appointed to state medical board

Gov. Bob Taft has appointed current OSMA President Lance Talmage, MD, Toledo, to serve as a member of the State Medical Board of Ohio. Dr. Talmage succeeds OSMA member Robert Heidt, MD, Cincinnati. Dr. Talmage's term on the board will end March 18, 2004. See "President's Perspective" for Dr. Talmage's comments about his new position.

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Federation of Medicine

AMA Report

Advocating through the courts

By Andrew M. Thomas, MD

This AMA Update concerns the use of litigation and our involvement in key health law cases via amicus briefs. Both through individual AMA action and through the Litigation Center, a cooperative effort between the AMA and other Federation societies, organized medicine has greatly increased its use of this effective advocacy tool.



Andrew M. Thomas,
MD

transferring head injury patients to a larger trauma center.

Fraud and Abuse:

The AMA is helping to lead a coalition including the AAMC, 30 state and specialty societies, and 13 academic medical centers in AAMC, *AMA, et al. v. United States* which opposes the PATH (Physician At Teaching Hospitals) audit process. The heart of the lawsuit is the claim that HCFA and HHS are unfairly, retrospectively applying rules regarding payment under the Medicare Act for services delivered by residents and fellows. As a direct effect of the lawsuit, one-third of these investigations were stopped and a number of others have already been redirected. After initially being dismissed, the case is currently in appeal.

Physician Deselection:

The Litigation Center and the California Medical Association have filed an amicus brief in *Potvin v. Metropolitan Life Insurance Co.*, arguing that a physician is entitled to "fair procedure" under state law when terminated without cause from a physician network. In *Zamora-Quezada v. HealthTexas Medical Group of San Antonio*, the Litigation Center is supporting two physicians who allege that their termination without cause violated the Americans with Disabilities Act by interfering with the management of patients with chronic illnesses to see the physician of their choice.

EMTALA:

Through amicus briefs, the AMA has been involved in two cases regarding the Emergency Medical Treatment and Active Labor Act (EMTALA). In *Roberts v. Galen of Virginia, Inc.*, the AMA fought to preserve the "wrongful motive" requirement in EMTALA as it was originally intended in the bill. Currently, in *Cherukuri v. Shalala*, the AMA, the American College of Surgeons, and the American College of Emergency Physicians are jointly arguing both the "wrongful motive" issue and also that the resulting \$100,000 fine was excessive. Dr. Cherukuri was fined that amount for following his rural hospital's long-standing policy of

transferring head injury patients to a larger trauma center.

continued on page 20

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Federation of Medicine

OSMA candidates for office



President-Elect
Walter J. Wielkiewicz, MD
Zanesville

Medical school: University of Cincinnati

Certifications: Dr. Wielkiewicz is certified by the National Board of Medical Examiners and the American Board of Family Medicine. He is also certified in Advanced Cardiac Life Support.

Current practice: Family Physicians of Southeastern Ohio, Inc.

Specialty societies: The American Academy of Family Practice, the Ohio Academy of Family Physicians, the Muskingum Valley Academy of Family Physicians. He is also a member of the American College of Sports Medicine.

OSMA roles: OSMA delegate from both Perry and Muskingum counties; councilor for the Eighth District; OMPAC "300 Club" member; PLAN member; chair of the Auditing and Appropriations Committee.

Other positions: Chair of the Family Practice Department at Bethesda Hospital; member of the Muskingum County Children's Services Board; medical director of the Mt. Aloysius Home for Men; medical director of the Perry County Alcohol and Drug Abuse Council.

Family: Wife, Kimberly; two daughters, Kristin and Amanda.



Secretary-Treasurer
John Thomas, MD
Wooster

Medical school: Case Western Reserve University School of Medicine

Certifications: American Board of Ophthalmology

Current practice: Wooster Eye Center, a private, four-member practice in Wooster. He also serves as

a clinical professor of ophthalmology at Case Western Reserve University's Department of Surgery.

Specialty societies: Dr. Thomas is a Fellow of the American College of Surgeons, and a member of several professional organizations, including the Ohio Ophthalmological Society and the American Academy of Ophthalmology.

OSMA roles: OSMA delegate from Wayne County; councilor for the Eleventh District; *Ohio Medicine* Resource Committee; OMPAC "300 Club" member; PLAN member; chair of the Auditing and Appropriations Committee; currently Secretary-Treasurer.

Other positions: Lions Club, medical outreach to Honduras.

Family: Wife, Judy; two sons, three daughters.

From the county files...

Montgomery County Medical Society tackles managed care

Dayton's physicians have teamed with local attorneys to address issues and concerns raised by managed care.

When it comes to managed care, the Montgomery County Medical Society (MCMS) may have the best solution for handling the number of concerns and frustrations that appear as a result of this health-care delivery system.

That's because, last year, Warren Muth, MD, then MCMS president, formed a managed-care committee, composed not only of representatives from MCMS, but the Dayton Osteopathic Association and the Dayton Bar Association as well. The group

met four times in 1998 to discuss issues raised by managed care, and last month, the committee sponsored an all-day, managed-care symposium for both Dayton physicians and lawyers.

"Our current president, Deepak Kumar, MD, served as the moderator for the morning session, while the president of the bar association, Judge Jeffrey E. Froelich, moderated the afternoon session," says Connie Mahle, MCMS executive director. "It's the first time we've worked together on a program of this type."

The symposium encompassed a broad range of subjects that included:

- Evolution of the medical profession to a managed-care industry;
- Proposals for legislative reform;
- Fraud and abuse policing from a

practitioner's perspective;

- ERISA;
- Delays and denials/pre-authorization;
- Appeals and Ohio Workers' Compensation System;
- Antitrust concerns;
- Unionization;
- Managed-care organization perspective; and
- Emerging legal strategies.

The event was deemed a success by the committee.

Whether or not the symposium will be repeated next year ("It's a possibility," says Mahle), one thing is certain. "The committee is here to stay," says Mahle. At least as long as managed care continues to dominate the medical marketplace. ■

Take Action

"Fram the county files..." is designed to show how county medical societies are identifying and responding to issues in their area with programs and activities that you may wish to borrow for your county. If you would like more information about this particular program, or about the recent seminar, contact Connie Mohle, executive director, Montgomery County Medical Society, 40 S. Perry St., Suite 100, Dayton, OH 45402, (937) 223-0990.

Practice Tips



Consults...revisited

An earlier article on consult and referral codes has generated discussion and still some misunderstandings. Here, Jillian Phillips, OSMA's coding specialist, revisits the issue.

The consultation codes are one of the services under major scrutiny by HCFA. Many times, audits result in downcoding of services from consultation codes to office/outpatient, and subsequent hospital service codes, resulting in monies being returned.

Consequently, it's increasingly important that physicians make every effort to communicate with each other regarding what they want when they send a patient to another physician. Are they sending the patient for evaluation and management (i.e., to take over care)? Or are they merely requesting opinion/advice on how to manage a particular problem? In most cases, the action will be a referral. There are certain documentation requirements that must be satisfied, says HCFA, when a consult

may be billed and preserved as such. Here are the facts (and what is not being argued):

- 1.) A consult is a request for an opinion/advice by one physician of another.
- 2.) Diagnostic/lab tests may be performed in order to reach an opinion/advice, and this information needs to be communicated back to the primary care physician.
- 3.) Treatment may be initiated at the time of the initial visit when medically indicated.

Here's the problem:

- 1.) Most of the time, when a patient is sent to a specialist for a known or unknown condition, it's for the sole purpose of managing the care, and is a referral. This means that a regular office/outpatient service, or subsequent hospital visit is the proper service to bill and not a consultation.
- 2.) An initial encounter with a patient may be preserved as a consult if it's documented in the medical record that:

- opinion/advice was requested on a specific or unknown problem; and that

opinion/advice was given on such. 3.) If treatment is initiated at the time, that is not a problem, but if the physician continues to treat the patient and makes note that the patient is to return for a continuation of that treatment — or if the physician continues to see the patient in the hospital — that doesn't look like a consult. It looks like a referral (i.e., a regular office/outpatient or hospital inpatient service.) Unless the primary physician gives the release for continued care and/or treatment, and unless that is documented in the medical record, the consultation that was performed will continue to be at risk of downcoding, and the physician will continue to be at risk of being charged with fraud. ■

Take Action

If you need more information about consults and referrals, or have questions about the material presented here, contact Jillian Phillips by faxing her at (614) 627-6763.

Itemized billing statements must be furnished upon request

A provision in the Balanced Budget Act of 1997 took effect April 1, obligating you to respond to any Medicare patient's written request for an itemized billing statement.

A provision in the Balanced Budget Act of 1997 now obligates you to provide an itemized billing statement to a Medicare patient upon written request. You must respond within 30 days, and you may not charge patients for the statements. This provision took effect for most Medicare Part

A and B providers on April 1.

If you do not regularly create or furnish hard copy itemized statements, here are some recommendations on what to include if a patient requests a statement from you:

- The name of the beneficiary.
- Date(s) of services.
- A description of the item or service that was furnished.
- The number of services furnished.
- The provider/supplier charges.
- An internal reference or tracking number. ■

Take Action

If you would like more information about this law and your obligations, you may visit the Health Care Financing Administration Web site, www.hcfa.gov/pubforms/transmit/ab99760, or access the HCFA Web site through the "Links" section of the OSMA Web site, www.osma.org. You may also contact the Department of Ombudsman Services of the OSMA, (800) 766-6762.

Medicare billing seminars planned

The OSMA is once again offering Medicare billing seminars to members and their office staffs. The half-day program addresses topics such as: fraud and abuse; E&M services; Y2K concerns; the HCFA 855 form; and proper billing guidelines in addition to the latest updates on Medicare billing and coding.

The seminars will be offered throughout the state during June and July. The schedule is as follows: (Each half-day session is offered both a.m. and p.m. except where noted.)

June 8 Cambridge, Holiday Inn Cambridge

June 9 Canton, Canton Hilton

June 16 Cincinnati, Holiday Inn Eastgate

June 17 Dayton, Dayton Convention Center

June 22 Elyria (1/2 day p.m. only) Holiday Inn Elyria

June 23 Mansfield, Comfort Inn North

June 29 Cuyahoga Falls, Sheraton Suites

June 30 Cleveland, Holiday Inn Independence

July 14 Youngstown, Holiday Inn Metroplex

July 15 Columbus (1/2 day p.m. only), OSMA Headquarters

July 21 Perrysburg, French Quarter Hotel

July 28 Columbus, OSMA Headquarters

Take Action

If you would like to register for the seminars, or need more information, contact Cathy Sonnholzer, OSMA Department of Ombudsman Services, (800) 766-6762, Ext. 6759.

Your Practice Guide

Medicare

Why claims are returned

Are your electronic Medicare claim forms bouncing back unpaid? Check the number of digits in your claim form's date. As of April 5, Medicare carriers are rejecting any claims with six-digit dates. Your claim must now have an eight-digit date or it's called non-Y2K compliant and kicked out the door.

How do you make your system compatible?

- Check the Health Care Financing Administration's Web site. (Link to it through OSMA's Web site, www.osma.org. Go to the links page, look under "Government/National.")

HCFCA's Web site includes "how-tos" on making your practice Y2K-ready.

- Medicare also offers free or low-cost billing software that's Y2K compliant. Ask Nationwide Medicare about its complimentary MITCH software. Training classes for using the software are available for a small fee.

- In addition, Nationwide Medicare offers an electronics claims testing system. For more information on Y2K testing, contact Electronic Data Interchange Technical Support at Nationwide, (614) 249-1180. ■



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Your Practice Guide

Spring cleaning your files

Which records to keep, which records to pitch? That depends on what's on the record. Financial records are more disposable than patient records which should be kept indefinitely.

Physicians are notorious collectors, says William Todd, JD, health-care partner at the Columbus-based law firm Squire, Sanders & Dempsey. And while there are lots of things they should collect, there's plenty to throw away. "Most physicians' offices I've been in, they have just stacks and stacks of journals, throw-away drug company inserts, and all that kind of stuff. Unless there's a specific need to keep them, they should be regularly cleaned out so it doesn't get to be an overwhelming burden."

Records can be equally burdensome. Some records are forever, but some can go. Here's how to decide what to keep and what to pitch as you spring-clean your office:

Financial records

If you keep billing and collection records for at least four full years, you can satisfy most audits. This year, you might throw away anything before Jan. 1, 1995.

Medicare can audit for up to five years, says Charles Y. Kidwell, JD, a partner in the Dayton office of Porter, Wright, Morris & Arthur. And even for tax purposes, it can't hurt to keep records that extra year. Although the statute of limitations on most audits is three years, the limit extends to seven years in the case of fraud. "So any business and financial records that you need to support tax returns, generally a good retention policy is either three or seven years. A lot of people compromise and say five as a practical matter."

The statute for payroll records also is five years, Kidwell says.

You don't have to keep paper copies of everything, Todd says. In

most cases, electronic records will do fine. If there's a dispute, however, be sure to keep hard copies too. "A lot of people think because they have computer records they have a complete record of a transaction. They forget that if you just keep a letter that was on your computer system, all you would have is the unsigned letter with probably a soft date; it doesn't really give you an indication that the letter was ever mailed."

Regardless of any statutes, before you throw anything away, check with your malpractice carrier, advises Bill Firy, OSMA director of ombudsman services.

Patient records

Keep patient records indefinitely. "I don't think you've got any good excuse for throwing away any patient records," Todd says. "To the extent they're dead files — if you haven't seen somebody in five or 10 years — you're probably better off putting them in storage somewhere than cluttering your office with them, but I don't know how you would justify not keeping them."

After a patient dies, you might start cleaning through the records, but not right away. "The last thing you want to do," Todd says, "is get a malpractice claim brought against you for failing to diagnose and — oops! I threw the file away when I found out Bob died. Because the claim's going to be, 'Well, the reason Bob died was you didn't do what you were supposed to do as a doctor.' Then you have no records to defend yourself."

In general, the statute for malpractice is one year following the point at which the patient knew or should have known about the claim. Say a bone fracture was improperly set. Kidwell says: "Follow-up treatment was sought from another physician. They identified the fact that the fracture should not have been treated in that fashion or may have required

continued on page 20

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How to help your patients understand "Medicare + Choice"

The AMA's new three-book series is designed to help smooth the transition to "Medicare + Choice" in your practice.

You can help your patients (and yourself) better understand the complexities of Medicare + Choice, the program designed by the federal government in 1997 to help seniors have more health-care choice, by obtaining the AMA's new booklet series on the subject.

The first of three booklets, *What is Medicare + Choice and Where Do Physicians Fit In?* is currently available, and focuses on the basics of the new program. For example, it describes differences between the original Medicare and the new options available under Medicare + Choice, and explains various aspects of the program, including contracts between plans and physicians, payment issues and rules on physi-

cian-plan relations.

Two future companion volumes are scheduled for publication later this year. They include: *Medicare + Choice: What You Should Say or Not Say to Your Patient and What You Need to Know about Providing Services to Medicare + Choice Patients*.

As Medicare + Choice evolves and as the federal government continues to work out the details of the program, the AMA will keep physicians apprised of these changes. ■

Take Action

You may order the first booklet in the series by contacting the AMA, (312) 464-5000. AMA members may call (800) 262-3211. The booklet is also available on the AMA Web site, www.ama-assn.org/od-com/whotmed.htm. You can access the AMA Web site through the OSMA Web site, www.osma.org. See the "links" section.)

Spring cleaning...

continued from page 19

surgery and surgery was not undertaken at the first treatment. Now, you're on notice. One year from that point."

The malpractice statute has exceptions, Kidwell says. In the case of a decedent, it runs until two years after death. And for minors, it runs until the age of majority.

With so much involved in creating a paper trail, it makes sense to throw out anything you reasonably can, Todd says. "You have the responsibility of keeping so many things mandatorily, you could just drown in paper if you didn't clear your stuff out every once in a while." —Jan Leibovitz Alroy

Take Action

For more information, contact the OSMA Division of Legal Affairs, (800) 766-6762.

AMA Update

continued from page 15

by physicians. Also, in discovery, it was found that they had actually been using a RBRVS reimbursement methodology since 1995 instead of the UCR-based system described. Summary initially found in favor of the Blues but the case may be appealed.

Peer Review Protection:

The Litigation Center has filed an amicus brief in the case of *Podgurski v. Grzy*. In this case, we are arguing that Connecticut peer review statutes should be construed to immunize physicians from litigation if they review a peer's professional performance in good faith. Fairview University Medical Center involves an attempt by the Minnesota State Board of Medical Practice to discover hospital peer review information as part of a disciplinary action against a physician.

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oses or any other cases which you feel that the OSMA, AMA or the Litigation Center should be involved in, please contact either the OSMA Legal Staff, (800) 766-6762 or the Office of the General Counsel of the AMA (AMA-3211).

www.osma.org

Visit the OSMA's web site frequently for updates on *Ohio Medicine* stories as well as the latest health-care news. Up-dates are posted on Tuesdays and Fridays. Check under "Hot News" for what's new.

Take Action

If you have any questions about these

Third-party update
**Anthem approves
payment for
Lovenox**

Anthem Blue Cross and Blue Shield approved payment last year for Lovenox treatment in the home setting for it's covered members. Lovenox (enoxaparin sodium), manufactured by Rhone-Poulenc SA, is a low-molecular weight heparins (LMWH) available for the inpatient treatment of acute deep-vein thrombosis with or without pulmonary embolism, and the outpatient treatment of acute deep-vein thrombosis without pulmonary embolism. Both indications require that Lovenox be administered in conjunction with warfarin sodium. ■

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Ohio Medicine (ISSN 0892-2454/USPS 405-200) is published monthly for \$40 a year by the Ohio State Medical Association, 3401 Mill Run Drive, Hilliard, Ohio 43026. Periodicals postage paid at Hilliard, Ohio and at additional mailing offices. POSTMASTER: Please send address changes to *Ohio Medicine*, 3401 Mill Run Drive, Hilliard, Ohio 43026.

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Colleagues

Newsmakers

DANIEL W. BENSON, MD, Toledo, received a three-year appointment as cancer liaison physician for the hospital cancer program at St. Charles Mercy Hospital.

JEFFREY M. BOORSTEIN, MD, PhD, Toledo, was recognized by the American Medical Association as a local and national physician leader. He was chosen by the AMA as one of 45 physicians from the United States to attend a pilot program given in conjunction with the Harvard School of Public Health. He is the secretary-treasurer for the Northwest Ohio Radiology Society, and has been named president-elect of the organization.

JEFFREY A. BROWN, MD, Toledo, was elected to a three-year term as a member of the board of directors of the American Association of Neurological Surgeons. He was also elected to a six-year term as a member of the Medical Advisory Board of the Trigeminal Neuropathy Association.

TODD COOPERIDER, MD, Toledo, was elected vice president of the Ohio Society of Anesthesiologists at the group's annual meeting.

THOMAS N. DETESCO, MD, Youngstown, was recently installed as the 127th president of the Mahoning County Medical Society. He follows a family tradition as his father, Dr. Andrew Detesco, held that position in 1958. An internist, Dr. Detesco maintains a practice in Boardman, Ohio. Other elected officers are Janardan R. Tallam, MD, president-elect and Richard J. Marina, MD, secretary-treasurer. Dr. Tallam specializes in emergency medicine, while Dr. Marina is a gastroenterologist.

LEE W. HAMMERLING, MD, Toledo, has been elected to the Medical Leader-

ship Forum, a division of the Governance Institute, which provides educational services for health-care organizations to strengthen medical leaders, boards and senior management.

EVELYN V. HESS, MD, MACP, Cincinnati, was named one of the *Cincinnati Enquirer's* "Women of the Year". Dr. Hess, professor of immunology in the University of Cincinnati College of Medicine, Department of Internal Medicine, was one of 10 Women of the Year for 1999. The annual Women of the Year are selected from hundreds of nominations to celebrate the work of local women who are ambassadors for almost every person and community cause in Greater Cincinnati.

S. AMJAD HUSSAIN, MD, Toledo, was recently installed by The Academy of Medicine of Toledo and Lucas County as the 142nd president. Other elected officers include: Patrick W. McCormick, MD, neurosurgeon, president-elect; Thomas J. Coturi, MD, gastroenterologist, vice president; William O. Murtagh Jr., MD, plastic surgery, secretary and William C. Sternfeld, MD, general surgery, treasurer.

MOLLY KATZ, MD, Cincinnati, received the Great Rivers Girl Scout Council's Woman of Distinction Award for 1999. The awards go to five women who have demonstrated strong initiative, individual integrity and personal leadership in meeting vital community needs.

DANIEL S. MURTAGH, MD, Toledo, was elected to the executive committee of the North Central section of the American Urologic Association.

RAMON Z. SEVILLA, MD, Toledo, received a three-year appointment as cancer liaison physician for the hospital cancer program at Riverside Mercy Hospital.

JOHN B. STENGLE, MD, Toledo, has been named a fellow of the American College of Surgeons.



WILLIAM C.
STERNFELD, MD,
Toledo, was elected to
the Board of Governors
of the American Col-
lege of Surgeons as
Governor-at-Large
from Ohio.



William
C. Sternfeld, MD

CREIGHTON

WRIGHT, MD, Cincinnati, director of surgery at Jewish Hospital, will receive the Dr. Samuel Kaplan Visionary Award, the highest local award offered by the American Heart Association/Southwest Ohio Chapter for years of surgical accomplishments, including helping to pioneer the use of lasers to reopen clogged arteries.

STEVEN R. ZEIDNER, MD, Toledo, participated as the physician expert in a symposium on Compliance Issues in Radiation Oncology at the annual meeting of the American Society of Radiology and Oncology in Phoenix. He was also installed as president of the National Council of Regional Radiation Oncology Societies.

Obituaries

SYDNEY S. DEUTCH, MD,
Dayton, Tufts University School of
Medicine, Boston, 1934; age 92;
died Jan. 5, 1999.

DAVID C. HUMPHREY, MD,
Chagrin Falls, University of Kansas
School of Medicine, Kansas, 1943;
age 80; died Jan. 19, 1999.

PAUL KEZDI, MD, Dayton,
Orvosi Fakultas Tudomanyegyetem,
Budapest, Hungary, 1942; age 84;
died Jan. 6, 1999.

LOUIS LIEDER, MD, Cleveland,
Case Western Reserve University
School of Medicine, Cleveland,
1930; age 92; died Jan. 24, 1999.

DAVID MARSALKA, MD, Co-
lumbus, Ohio State University
College of Medicine, Columbus,
OH, 1980; age 43; died Jan. 4,
1999.

RALPH ROSEWATER, MD,
Cleveland, Ohio State University
College of Medicine, Columbus,
OH, 1934; age 90; died Jan. 10,
1999.

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June 1999

Ohio Medicine

3

prompt pay problems are troubling some members. To solve them, the OSMA plans a multifaceted approach, including direct communication with insurers and legislative changes if necessary.

4

Defining underserved areas is not easy; the government learned after its proposed definition received more than 800 letters of protest.



9

Ohio's medical schools' curricula these days includes not just some education in alternative medicine.



11

Domestic violence continues as a social problem in Ohio despite OSMA's efforts to curb it through its educational handbook *TrustTalk*. Now, *TrustTalk* is back, updated and revised.

16

OSMA Annual Meeting is captured in pictures, including highlights of the opening and final session and other special events.

House affirms Council's action, authority in AMC revocation

The House of Delegates agreed that the OSMA Council acted within its authority, and after reviewing the issues approved revoking the Academy of Medicine of Cleveland's charter.

The OSMA House of Delegates adopted a resolution during its Annual Meeting last month that indicated the OSMA Council acted in accordance with the OSMA Constitution and Bylaws in revoking the charter of the Academy of Medicine of Cleveland (AMC), that it had the authority to take such action, and, further, upon review of the matter, the House voted to approve council's action in revoking the AMC charter.

On a separate but related matter, a resolution committee recommended unanimously that the House reject an emergency resolution offered by AMC. That resolution had asked the OSMA to reinstate a mediation agreement that existed between the two organizations from December 1998 until January 1999, when a violation of the agreement by AMC prompted OSMA to revoke the county society's charter for a second time. AMC responded by filing a lawsuit against the OSMA.

A substitute resolution, offered on the floor of the House during its Final Session, however, asked that AMC be "encouraged to apply for an OSMA charter" once it had met seven conditions – including compliance with OSMA bylaws and suspension of AMC's lawsuit against the OSMA. The House decided to refer that resolution to the OSMA Council.

OSMA Fifth District Councilor, Daniel van Heeckeren, MD, Cleveland, who introduced the substitute resolution, said it gives the council an opportunity to review the events and to create a compliance oversight committee that would supervise the process of returning AMC as a component society of the OSMA. The resolution, he added, was presented to the House by him as "an olive branch" in hopes that healing between the two organizations could begin.

By referring the issue to council, the House gave that body complete authority to resolve the current dispute as it sees fit. *Ohio Medicine* will continue to provide updates.

In other business, the House agreed to change its policy regarding Advanced Practice Nurse (APN) prescribing, in anticipation of an APN prescribing bill (Senate Bill 99) and



OSMA's new president...David J. Utlo, MD, Canton, spoke of "service above self" in his presidential address and said he is optimistic about the challenges ahead.

its companion House Bill 241) passing the Ohio Legislature this session. This resolution sets in place as new OSMA policy a number of rules and regulations before the OSMA will support legislation permitting APN prescribing.

Representatives from both the Ohio Academy of Family Physicians and the Ohio Chapter of the American Academy of Pediatrics testified on the importance of OSMA securing a seat at the legislative bargaining table on this issue.

Opponents, including a representative from the American Academy of Anesthesiologists, cautioned that, although medicine may be on the losing side of this legislative battle, "we have to do what's right for our patients."

The House, however, adopted the amended resolution changing a long-standing policy opposing APN prescribing. ■

Take Action

For a chart of actions taken by the House, or a copy of the APN resolution visit the OSMA Web site, or call the *Ohio Medicine* reader response line (800) 766-6762 Ext. 6580. Ask for Item #14-99 (chart) or Item #15-99 (resolution).



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Bills, Laws & Rules

OSMA builds strategy to alleviate insurance payment problems

Results of a recent OSMA survey helped define the major areas of concern. As a result, the OSMA is developing a multifaceted approach to solve the prompt pay problems.

In February, the OSMA sent a survey to a random sample of members and group managers in an effort to compare payment of claims by Health Insurance Corporations (HICs) in Ohio. A revised version of the survey was distributed in April — again to members and group managers.

Two major issues have emerged as a result of the surveys:

- At least half of all claims filed are not paid on original submission. They are either denied, pended/suspended or partially paid.
- Of those that are paid on original submission, a significant number are paid within the legally mandated 24 days.

"It is clear from our evaluation of the responses that we need to consider a multifaceted approach to solve problems with the payment system," says Todd Baker, OSMA director of Medical Economics and Advocacy.

"Strengthening the prompt pay law and its enforcement addresses one facet of the problem (timely payment of clean claims). However, at the same time, we need to reduce many of the administrative complications with the payment process that cause over half of claims to not be paid on original submission and force members' practices to spend an increasing amount of staff time to get paid."

He suggests strategies might include:

- direct communication/negotiation with insurers;
- legislative changes;
- regulatory reforms;
- increased education of OSMA members and their staffs to enhance



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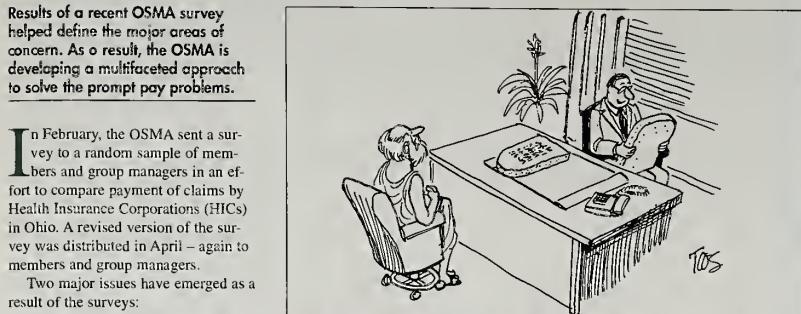
The ODI says some prompt-pay problems arise from denied claims. Claims are often denied because they are:

- incomplete;
- not filed on the correct form or with correct CPT codes;
- lack sufficient documentation; or
- lack sufficient statements as to why that course of treatment was chosen.

How the OSMA can help

• The OSMA offers a coding service for members who need assistance in this area. Fax or e-mail your coding questions to Jillian Phillips, OSMA Department of Ombudsman Services, fax: (614) 527-6763, e-mail: ombud@osma.org. Or call her at (800) 766-6762, Ext. 6758.

• Register yourself and/or your staff to attend one of the OSMA Medicare billing seminars. The seminars provide updated information on filing Medicare claims. To register, or for more information, contact Cathy Sonnhalter, OSMA Department of Ombudsman Services, (800) 766-6762, Ext. 6759.



"Well, yes, you're right, doctor. The claim looks fine to me. Now, when did you say you submitted it to us?"

their coding and billing skills.

Baker concludes, "Using a variety of approaches provides the best chance for meaningful changes in the system

that will ultimately benefit not only the physician, but the insurer and the patient as well." — Yvonne H. Burry

Can you mix practice and politics?

New guidelines from the AMA suggest it's possible for political discussions to take place in practices, if the interests of the patient remains the focus of the visit.

Here's a test for your sensitivity IQ: If one of your patients is in the office for a visit, is it appropriate that you get into a discussion about something political, for example, Governor Taft and the patient bill of rights?

On one hand, a casual discussion could help put the patient at ease and potentially enable a bonus situation of fulfilling your role as educator when you provide important information to a

concerned citizen. On the other hand, the patient is in your office because of a medical situation and will get only a few precious minutes of your time. Is it in the patient's best interest or in the patient's interpretation of cost-effective care that you spend time on political issues?

The issue is when is it appropriate to seize an opportunity for a politically based discussion between the physician and a patient or family is now the subject of new AMA guidelines.

Patients are vulnerable

"The intent of the guidelines is to guard the vulnerability of the patient at these times (office visits)," says Victoria Ruff, MD, Columbus. Dr. Ruff is a



Victoria Ruff,
MD



Donel W.
Hondele, MD

critical care specialist who has participated on the AMA's Council on Judicial and Ethical Affairs. "Most physicians feel they can judge a conversation and decide if it is service to relax a patient," says Dr. Ruff.

continued on page 4

AMA guidelines on practice, politics

1 It is laudable for physicians to run for political office, to lobby for political positions, parties or candidates, and in every other way to exercise the full scope of their political rights as citizens. These rights may be exercised individually or through involvement with organizations, i.e. as professional societies and political action committees.

2 Physicians have a responsibility to keep themselves well-informed as to current political questions regarding needed and proposed changes to laws concerning access to health care, quality of health-care services, scope of medical research, and promotion of public health.

3 Communications by telephone or other modalities with patients and their families about political matters must be conducted with sensitivity to patients' vulnerability and desire for privacy. Political conversations are inappropriate when patients or families are emotionally pressured by significant medical circumstances. Physicians are best able to judge both the intrusiveness of the discussion and the patient's level of comfort. When conversation with the patient or family concerning social, civic, or recreational matters is acceptable, discussion of items of political import may not be inappropriate.

4 Physicians should not allow their differences with patients or their families about political matters to interfere with their delivery of professional, high-quality care.

Take Action

To order a copy of the AMA guidelines on political communications, contact the Ohio Medicine reader response line, (800) 766-6762, Ext. 6580, and ask for item #11-99.

Can you mix practice and politics?

continued from page 3

"Of course, a political conversation needs to be done properly," says Daniel W. Handle, MD, Lake Milton, chair of the Ohio Medical Political Action Committee (OMPAC). "Political conversations can occur on a simple basis, when a physician is just getting to know a patient. But such conversations cannot take the place of why the patient is in the office."

"Patients are often concerned about the burning issue of managed care," says Dr. Handle. "For example, who will make the decision on behalf of the patient's welfare - the HMO or the doctor?" he says.

Physician as educator

Dr. Handle says there was "strong

disagreement on both sides of the political discussions issue" at the AMA annual meeting. "The word, 'doctor', means educator, so you can have legitimate reasons to discuss an issue. And it can be done in a jocular fashion, in the correct setting. But it needs to be done properly." Dr. Ruff agrees that there is a "political correctness" component to moving from medical to political topics with a patient or the patient's family. "...We put the patient first, well ahead of other issues... We understand that sometimes a patient is stressed and it might not be the time to bring up a political topic. The intent is to guard the vulnerability of the patient at this time."

Literature can be available
For the physician who wants to help educate patients on salient political issues but has a concern over office visit discussions, Dr. Ruff suggests providing copies of relevant literature in the waiting and/or examination rooms.

In today's complex and highly charged world, the political aspects of medicine will likely be of greater interest to both physician and patient. The guidelines are there simply to ensure that the interests of the patient remains the focus of the visit. —Yvonne H. Bury

Rural practices

New definitions of underserved, shortage areas on hold



When the government proposed changes in the definitions of "health-professional shortage areas" and "medically underserved populations," it received more than 800 letters of concern.

The Health Resources and Services Administration is revisiting its proposal to redefine medically underserved populations (MUPAs) and health-professional shortage areas (HPSAs) after receiving more than 800 letters of protest when the proposed rules were published in the *Federal Register*.

Among the issues cited by letter-writers:

- **A proposed 3,000-to-1 population-to-provider ratio.** "We're getting a lot of feedback to the effect that no provider can handle 3,000 people," says Richard Lee, public health analyst for the Bureau

of Primary Health Care. "It's too high."

- **Inclusion of nurse-practitioners and certified-midwives in the population-to-practitioner count.** Scope of practice for such nonphysician practitioners varies from state to state. "You don't always know who's in a primary care practice, and who's doing something else," says Lee.

- **Exclusion of the percentage of elderly within the weighting system.** In frontier areas, the population may be too sparse to meet the 3,000-to-1 guideline, but may include a large percentage of elderly residents.

Changes affect incentive pay

The changes could affect federal incentive payments, grants, scholarships and other programs — to the tune of millions of dollars — that pull physicians into rural areas. The HRSA designation allows for cost-based reimbursement, and, without that, says Stephen Ulrich, MD, New Lexington, he couldn't stay in business. "It costs a certain amount of money to provide good care," he says. "If you get below that point, you will not be able to attract quality physicians, you won't be able to attract quality people to work in your office, you will not be able to afford to purchase equipment, facilities,

and provide care," Dr. Ulrich's Perry County practice is one of about 10 rural practice clinics in Ohio.

Another problem with the proposal is the merging of the two entry points for the shortage designations, says Bill Finnerock, executive director of the National Association of Rural Health Clinics in Washington, D.C. A medically underserved designation is based on an area's population, and a health-professional shortage area is a geographic determination. The proposed rules set up a scoring process for the MUA designation. In addition to looking at infant mortality, low birthweight, and poverty, a new criteria would be whether or not individuals have difficulty speaking English. The percentage of elderly would no longer be a criteria. If an area didn't score enough points, it wouldn't qualify as an MUA. If it did qualify, it could go on and receive a second designation as a health-professional shortage area, based on the practitioner-to-population area ratio. But there would be no separate and independent mechanisms for being designated a health-professional shortage area.

continued on page 6

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Don't prescribe controlled substances for patients sight unseen

When the medical board drafted its recent rule on Internet prescribing, the board also set its position on prescribing for all patients – sight unseen.

The board's recent rule on Internet prescribing reemphasizes the board's position when it comes to prescribing controlled substances for any patient the physician has not examined or diagnosed. That action is considered by the board as falling below the minimal standards of care.

The rule does provide exceptions:
1.) If the physician is in consultation with the primary treating physician and the prescription is not for a controlled substance, then the physician may prescribe. This allows physicians to continue prescribing for patients in emergency situations.

2.) If the physician has accepted a new patient, and is in the process of scheduling or has already scheduled an appointment, the physician can prescribe drugs to alleviate suffering until the patient can be seen.

PA list may include prohibited procedures... The board's Physician Assistant Committee is working on draft rules that would include a rule

Medical Board Report

listing those procedures that PAs will be absolutely prohibited from performing, as well as a list of services for which the physician will need to submit a supplemental plan. The list is defined as a "work in progress" and is by no means complete, but at the moment, "low-risk vaginal deliveries" are included on the "prohibited" list.

Training certificates may not expedite licenses... Now that the medical board requires residents to have training certificates, will the process of obtaining a medical license be faster? Not necessarily, say board staff members. The law requires the Federation Credentialing Verification Service (FCVS) of all Ohio license holders. However, the FCVS is not required for a training certificate. Residents, therefore, will still have to go through that process when applying for a license. The board may study whether or not the licensing process can be accelerated in the future for trainees. ■

Underserved...

continued from page 4

That process wouldn't account for all the reasons a community might be underserved, says Finerfrock. Some communities, for example, may not qualify as an MUA, but they simply don't have a sufficient number of practitioners in the community to meet the demand for health care.

Patient care should be focus

Or the physicians they do have can't afford to take Medicare patients. Physicians must be able to focus not only on their individual patients, says Dr. Ulrich, but on their responsibility to the commu-

nity. "Then we can truly be patient advocates and advance the cause of medicine. At times, we become so focused on our own legitimate needs that sometimes we lose sight of that larger picture. It's critical that we get back to focusing on good patient care and service. The (HRSA designation) lets us do that in rural areas where it might not be tenable."

The agency hears that, says Lee. "It's going to take us a little while to figure out where we go from here. We're not going to implement (the rule) as proposed. The issue is, how do we revise this?" — Ian Leibovitz, Alloy

Bill tracker

Legislative update

Duty-to-warn bill passes

Legislation changes quickly. Check the OSMA Web site, www.osma.org for the latest status of health-care bills.

Bills passed:

(The following bills have all passed the Ohio House and are now in the Senate.)

- **House Bill 16, health-care study.** Creates a task force to study consumer access to preferred provider plans, point-of-service plans, and other open-panel plans for health-care coverage. An approved amendment to the bill pushes back until January 2000 the date the task force is required to submit its report.

Sponsor: Rep. J. Donald Motley (R-West Carrollton)

OSMA position: Support

OSMA contact: Nick Lashutka, Ext. 6747

- **House Bill 71, patient behavior.** Establishes procedures for mental health-care providers to follow in predicting, warning of or taking precautions to prevent the violent behavior of mental health clients or patients in order to qualify for certain immunities.

Sponsor: Rep. Rose Vesper (R-New Richmond)

OSMA position: Active support

OSMA contact: Nick Lashutka, Ext. 6747

Status: The bill passed the Senate and awaits the governor's signature.

- **House Bill 121, asthma inhaler.** Permits students of school districts, community schools and chartered nonpublic schools to carry asthma inhalers approved by the students' physicians and parents.

Sponsor: Rep. Randall Gardner (R-Bowling Green)

OSMA position: Support

OSMA contact: Maria Bump, Ext. 6741

Bills introduced:

(The following bills have been introduced)

- **Senate Bill 121, tobacco sales.** Raises to 21 years the age at which cigarettes and tobacco products may be purchased by individuals in Ohio. Those under 21 years would be prohibited from possessing tobacco products.

Sponsor: Sen. Grace Drake (R-Solon)

OSMA position: Support

OSMA contact: Maria Bump, Ext. 6741

- **Senate Bill 130, drug sales.** Requires the State Board of Pharmacy to establish a list of drugs that may be hazardous when different brands or generic equivalents are interchanged and requires a pharmacist refilling a prescription for such to drug to notify the patient and the prescribing physician concerning dispensing another brand or a generic equivalent of the drug.

Sponsor: Sen. Grace Drake (R-Solon)

OSMA position: not yet considered

OSMA contact: Krista Bistline, Ext. 6748

- **House Bill 397, prescription services.** Relates to coverage for prescription drug services, provided by "any willing pharmacies" under policies of sickness and accident insurers and health insuring corporations.

Sponsor: Rep. Bryan Williams (R-Akron)

OSMA position: not yet considered

OSMA contact: Nick Lashutka, Ext. 6747



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ODI file of prompt-pay complaints falls short of reality

To the Editor:

I'm encouraged to see that more than just physicians are concerned about the problems of slow and non-payment for medical services by insurance companies. I'm glad that one of our elected officials, Rep. Kevin Coughlin, is planning on submitting legislation to correct matters. I feel he has a major task ahead of him.

I was amazed at the recent article in *Ohio Medicine* that quoted the Ohio Department of Insurance (ODI) as having only 700 complaints regarding prompt payment. Upon contacting the ODI, their representative stated that there have been 1,203 complaints. I find this amazing as my office of four professionals alone submit between 30-50 complaints per month, and have done so for the past four years. Therefore, we have submitted approximately 1,900 complaints. In discussing this matter with the department, they have registered 56 complaints from my office. They are presently researching these discrepancies. They did state that it was their

policy not to respond to complaints, "We're not here to help you get paid on time." Their representative also stated that my practice of complaining about violations of state law was "an anomaly" and would not warrant investigation.

The ODI also had numerous explanations of how they could take no action because they had no authority over self-funded plans, and only limited authority over any third-party insurance administrators. I cannot pretend to say that I understand this. Based on this information, I would be willing to challenge anybody who questions whether there is a problem with payment for medical services in the state of Ohio.

Charles S. Burke, MD
Perrysburg

For information on what the OSMA is doing to address the prompt pay problem, see page 3.



letters

Stop the lawsuits

To the Editor:

I have been a member of both the Cleveland Academy and the OSMA since opening my practice 10 years ago. I have been generally satisfied with the services I have received from both organizations until the recent warfare between OSMA and the Cleveland Academy started last year. Is this how my dues are being spent? On endless lawsuits? I want this to stop. Resolve these issues or I will vote with my feet, and urge other colleagues to do the same. At the end of my present membership, I will belong to both organizations, or neither.

Edward C. Horwitz, DO, FACC
Cleveland

Editor's note: All legal expenses incurred by the OSMA thus far are the result of responding to lawsuits filed against it by the Academy of Medicine of Cleveland. The OSMA position throughout has been to abide by the policy set by the OSMA House of Delegates requiring membership in both organizations.

September 17, 1999

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Mary Carskadon, Ph.D.

Michael Thorpy, M.D.

Robert Hinkle, DDS

Helmut S. Schmidt, M.D.

TOPICS:

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Parasomnias

Treatment options for Sleep Apnea

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Indepth Report

Alternative medicine

Ohio medical schools add alternative medicine to curricula

Practitioners are watching the alternative medicine trend to see if and how it will integrate with conventional medicine. Meanwhile, medical schools are preparing students for both.

Ohio medical colleges are paying attention to alternative medicine (AM). That's because, these days, physicians need to be able to both discuss and advise their patients who want to bring various healing strategies into their health care. Here's a sample of what's going on:

At Ohio State University, Dr. Daniel Clinchot, MD, director of medical humanities and associate professor of physical medicine and rehabilitation, says that AM is part of the medical humanities training that all students attend. Physicians with experience in chiropractic, ayurvedic and homeopathic practices, for example, provide in-depth tutorials to the students and relate their work in the community. "This is part of the first-year curriculum," he says. "In the third and fourth years, when these students do see patients, they can bring this knowledge to the clinical setting." An Alternative Medicine Fair, held in April, provides an optional event that allows students access to AM practitioners. OSU has applied for a grant that would provide additional student training opportunities and expand CME options for practicing physicians.

The University of Cincinnati has had AM as a family medicine program elective for almost a decade. Bruce Gebhardt, MD, is director of the alternative medicine elective and an assistant clinical professor in family medicine. "We prefer to have an MD present the topics as part of a faculty

group and with a critical review of the literature," he says. But many AM providers in the community, who have significant in-depth knowledge also contribute to courses. Students focus on case reports and see how AM integrates into allopathic medicine, says Dr. Gebhardt. Third-year students get regular lectures on over-the-counter medications, including herbs. Students in the Leaders in Medicine program regularly have brown-bag lunch topics on AM. Fourth-year students regularly

long, and spend several hours discussing AM topics and clinical applications. An AM club maintains significant literature resources and holds regular meetings and seminars. MCO faculty are now developing elective third- and fourth-year clerkships to bring even more AM experiences to students working effectively with conventional medical care. Among AM therapies, a number of MCO physician have special training in and practice acupuncture.

Conran adds that knowledge of traditional or folk medicine is also being integrated into the program because "you need to cooperate with cultural issues and traditional things; people believe in them."

A major curriculum revision is in the works at Ohio University's College of Osteopathic Medicine.

says Peter Dane, DO, assistant dean for curriculum and associate professor of emergency medicine. This fall's first-year class will begin a mostly case-oriented curriculum that is reorganizing topics around the person and the medical complaint rather than the traditional subject areas. "Our goal is to accomplish a fairly tight integration of disciplines...including relevant topics...and improve the psychosocial aspects of medicine." Among the aspects of treatment in this approach will be AM topics, such as acupuncture, nutrition, homeopathy, massage and herbal remedies, when appropriate to the case



At OSU all medical students are exposed to alternative medicine through their medical humanities training.

discuss acupuncture, chiropractic and manipulative therapies. This summer the collaborative Health Alliance of four Cincinnati hospitals will open an integrative medicine center that will focus on AM for health care and provide additional hands-on learning opportunities.

Philip Conran, DVM, PhD, is chair of the curriculum committee and acting academic chair of the department of pathology at the Medical College of Ohio. Medical students (all years) at MCO have an elective option via a seminar series. Conran says that speakers come in once a week, all semester

being studied. OU's summer program, required after the second year of training, and some evening elective courses will also likely include AM topics. OU's goal is to produce students who are well informed about conventional and complementary therapies working together. "The osteopathic arena has a much greater acceptance of alternative therapies," says Dr. Dane.

Wright State University is now finishing year two of a dramatically revised curriculum, says Albert Langley, PhD, associate dean for academic affairs and professor of pharmacology and toxicology. "AM is being longitudinally integrated across the curriculum rather than in one course," he says. Faculty and outside experts present AM topics. Third-year students will soon get AM topics integrated when appropriate; fourth-year students have had AM seminars. "We want practitioners to know what's available and what their patients will be using." WSU emphasizes evidence-based medicine and looks to the literature for support and evaluation.

AM in Perspective

The pervasive acceptance of AM therapies by patients has helped initiate the placement of such topics into medical curricula. Practitioners are watching to see if AM is just a trend or whether it will fully integrate with conventional medicine in the healing arts. Important to this process will be definitive, well-constructed research, conventionally trained physicians who have added AM experiences to their skillset and are now sharing this knowledge with students and colleagues, and acceptance of AM by third-party payors. Progress in all three areas is ongoing. — Yvonne H. Bury

Take Action

These Web sites were suggested by Therese Zink, MD, University of Cincinnati, who provides herbal information to medical students.

NIH Office of Dietary Supplements:
<http://odp.od.nih.gov/ods>

FDA: <http://vm.cfsan.fda.gov/~dms/supplmnt.html>

Healthgate: www.healthgate.com

US Pharmacopoeia:
<http://micromedex.com/po-altm.htm>

American Botanical Council:
www.herbatalog.org

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December 1 • Wed ————— **Toledo**
Hilton

December 2 • Thurs ————— **Dayton**
Marriott

OSMA News



OSMA expands CME services

The OSMA has changed the name of the Continuing Education and Outcomes Research department to Educational Services. The change means greater resources available for special educational initiatives, CME accreditation and other educational activities. The group's goals include developing more creative and innovative activities, concentrating on rural communities and primary care, and considering a rotating "general topics" curriculum.

Topping the list of Educational Services' activities now under way is a major initiative to address women's health issues for primary care physicians.

In another venue, Educational Services is expanding its joint-sponsorship efforts to partner with several organizations or alliances outside the OSMA to develop CME courses for physicians.

Finally, Educational Services has added an education coordinator, Mary Giuliani Whitacre to its staff.

Other education topics being considered in the next few months include: recent changes in DNR (do-not-resuscitate) rules, preparing for Y2K, and a joint meeting planned with the Association of Ohio Health Commissioners in November.

Although the number of CME accredited sponsors in Ohio has reached an all-time high of 72, the OSMA continues to seek opportunities across the state for physicians to earn quality CME, especially in underserved areas of the state. The OSMA also is attempting to expand CME training beyond the traditional, didactic CME lecture. Goals here are to develop interactive topics and a greater variety of presentation formats for Ohio physicians. — *Yvonne H. Burry*

Take Action

If you would like more information about educational opportunities, please contact Janet Shaw, director of Educational Services at (800) 766-6762 Ext. 6737 or e-mail: education@osmo.org.

Women's Health Initiative

Education still needed on domestic violence issues

This summer, the OSMA will release its revised, updated version of *TrustTalk* in hopes that Ohio physicians will, once again, help stop the cycle of domestic violence.

Seven years have passed since the OSMA released *TrustTalk*, a handbook designed to educate physicians on recognizing and treating victims of domestic violence. Since then, domestic violence has become more widely recognized as a social issue. But it has not disappeared.

National statistics still show the number of domestic violence victims at more than 4 million a year. One in four women are likely to be abused by a husband or partner during her lifetime. And these figures represent only those victims who were hurt so severely they required medical attention or who involved the police. The actual number of domestic violence victims is probably far greater than statistics reveal because many cases go unreported out of embarrassment, fear or both.

The OSMA's concern is that, after the initial attention paid to this subject in 1992, physicians may no longer be asking their patients routinely about abuse. That's why the association has updated and revised *TrustTalk*.

The new version serves several purposes:

- provides you with the most current clinical guidelines on diagnosing and treating abuse as outlined by the AMA and other sources;
- updates you with regard to Ohio's laws on this subject;
- provides you with an updated referral list of domestic violence shelters, as well as new resources, available in printed literature and on the Web;

- gives you a tool to use in screening victims of domestic violence. A pocket-sized card, included with the book, shows the kind of history that suggests domestic violence behavior and physical clues, ways to communicate with domestic violence victims, assessing their safety, how to make referrals and how to document cases of domestic violence;
- reminds you to routinely ask your patients if they are experiencing abuse from a partner or spouse.

Because domestic violence continues to be a social and health issue for all of Ohio's physicians, the OSMA sought to make this subject part of its two-year "Women's Health Initiative," which kicked off in May with an edu-

cational campaign on osteoporosis.

The new, revised *TrustTalk* will be distributed this summer to all OSMA members in selected primary care areas (family practice, internists, general practice, obstetricians-gynecologists.) The OSMA hopes that through increased awareness, including the ongoing concern of physicians, the devastating cycle of domestic violence can be broken. ■

Take Action

If you have questions about the revised versions of *TrustTalk* or about the Women's Health Initiative, contact the OSMA Division of Public Affairs, (800) 766-6762.



Osteoporosis kickoff... Jennifer Lopez, chief of the office of Women's Health Initiatives places a boutonniere on OSMA President David Utok at the Women's Health Awareness Day held at the Statehouse. Dr. Utok spoke on OSMA's Women's Health Initiative project, which will also include education on domestic violence and breast cancer.

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President's Perspectives

An old message for a new millennium

In six months, we'll be on the cusp of a new millennium. I'm excited by the prospect of leading the OSMA into the Year 2000. As its youngest president, I believe I'm up for the challenge. But I'm warning all of you, I can't do this alone.

Organized medicine's greatest strength lies in its ability to give stronger voice to our profession's concerns - a familiar litany that begins with managed care and moves on to fraud and abuse, prompt payment of claims, HMO accountability, and development of the "new" E&M documentation guidelines. This year, we add a new worry, Y2K. Always, we ask, "how will this affect our patients?" And the answers are seldom easy to hear.

My job, as president, is to set the course and steer the ship through these rough seas. Your job is to come on board.

Suppose you didn't. Suppose you and your colleagues - all of Ohio's physicians in fact - set sail in their own small boats. What would the course of medicine be then? Fragmentation. To continue the sea analogy, shipwrecks would litter the coast.

Medicine can only grow and progress if we stay together and keep the channels of communication open. It's an old message but one that may be more appropriate than ever as the year 2000 approaches.

After all, from here, medicine's future looks as bright as a new minted coin. We have technology and pharmaceuticals that doctors only dreamed of a thousand years ago. But we know



David J. Utlak,
MD

continued on next page

continued from page 12

These advantages are only part of the picture. They are tempered by the concerns I've already mentioned, and ones you can name on your own. The profession of medicine has progressed since the last millennium, no doubt about it. But progress in our technology has not always been matched by the changes in politics, economics and society.

More marvels may await us in the year 2000 and beyond. I hope so. But if we are to ensure that our patients' rights are not further compromised as the millennium progresses, then we need to unite and stand together as our patients' advocates.

That has always been the role of the OSMA and organized medicine, and I don't see that position changing as the calendar turns. For more than 100 years, we have united on behalf of our patients. That's what our role will be in the next millennium as well. Whatever our differences, the patient is still our common denominator...the net that draws us closer together. Together we're strong. We can speak and act effectively. We can accomplish much that benefit our patients. When we act alone, we're cast adrift amid seas that are too tumultuous for single-handed sailing.

I invite you, this year, this millennium, to come on board. Be part of organized medicine's future. Be part of the OSMA.

I have no crystal ball. I don't know what awaits us over the horizon. I do know that I have direction and a vision. I know I can steer us past the eddies and shoals. But I can't do it alone. I need your strength, your cooperation, and your participation. The future of medicine and of the OSMA can only be as bright, as strong, as effective as its member-physicians. Join us. Our patients need us. And, ultimately, we need each other. ■

J. Steven Polsley, MD, is running for the AMA Council on Medical Services. Visit his Web page at: www.osma.org/polsley.html

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On the Web...

Campaign via the Internet

While other "physician/politicians" hit the campaign trail shaking hands and knocking on doors, OSMA member J. Steven Polsey, MD, Urbana, has taken to the Internet for his AMA campaign.

The family physician approached the OSMA about inserting a page on its Web site touting his campaign for a seat on the AMA Council on Medical Services. The Polsey site includes: a home page listing his record of service, credentials and endorsements; a question/answer section; his CV; and a place to send messages to him via e-mail. Visit the site at www.osma.org/polsey.html or click on the navigation button on the OSMA site.

The OSMA secured from the AMA a list of e-mail addresses of AMA delegates and alternates and sent them a blast e-mail telling them to vote for Dr. Polsey and inviting them to visit his Web page.

We'll let you know next month how Dr. Polsey did on his bid for a seat on the AMA Council on Medical Services. News via e-mail...Would you like to get a recap of the latest health-care news and legislative issues in Ohio via e-mail? If you'd like to receive a weekly newsletter via e-mail please contact Karen Kirk at kkirk@osma.org.

What you need to know about Y2K... We are just six months away from the year 2000. Whether you're anticipating major or minor problems in your office due to possible computer glitches, the OSMA is addressing the Y2K situation by running stories in *Ohio Medicine* and on its Web site at www.osma.org. A new pop-up survey on the Web site addresses the Y2K issue. Members can find more information on Y2K on the OSMA Web site in the "Bulletin Board" section. You can also post questions or concerns on the site. One of our computer-savvy members may be able to help. ■

Take Action

Comments and suggestions about the OSMA Web site are welcomed. E-mail: Karen Kirk at kkirk@osma.org or call her at (800) 766-6762.

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From the county files ...

Cincinnati Academy operates at the cutting edge

The Academy of Medicine of Cincinnati recently formed a task force to look at collective bargaining. "Not that we're necessarily interested in becoming a union," says Executive Director Russell Dean, "but we want to be ready for the time, if it comes, when nonemployed physicians can do some collective bargaining. I think it's pretty clear that most physicians don't want a lot to do with unions, but they would like to have the ability to act collectively when it comes to negotiating reimbursements. We want to make sure that organized medicine, at least at the county level, is ready to offer that should the laws change to allow it."

The academy is keeping up with the times. In May, it joined with the OSMA in sponsoring a meeting on alternative medicine. The joint program was one step in its bid to become an accredited provider of continuing medical education (CME) credit. In November, the academy will host its second computer expo. Dean expects "a couple hundred physicians" to visit hardware and software vendors at the show. The first expo, in 1997, was so successful, the academy decided to do it again, Dean says.

The Cincinnati Academy, founded in 1857, has 1,500 active members and an additional 800 members who are retired, students or residents, or outside Hamilton County. The academy has a budget of \$2.5 million and a staff of more than 40.

The academy comprises four corporations: The Hamilton County Medical Society is the chartered member of the OSMA. Academy Services is a for-profit wing. The Medical Foundation gives grants for health-related causes. And Medi-Club is a social and travel organization.

Last year the academy opened a fully equipped, state-of-the-art computer training center where it offers a regular series of introductory courses to the In-

ternet and software such as Microsoft Word, WordPerfect and Quicken. "A lot of the older and even retired physicians are taking advantage of this," Dean says. "We're very pleased."

The center also arranges special training sessions. "A physician can bring in their entire office staff in one sitting and get the whole staff up to speed on some particular software application they want," Dean says.

"The hospitals helped pay for this," he says. "It's an \$80,000 project. We got \$60,000 from the hospitals so that they could send physicians down and have them trained on a particular aspect of the software at the hospital."

Through the computer center, the academy participates in HealthBridge, a pilot community information system that allows multiple users to share patient, clinical and financial information. "It's a secure intranet," Dean says. "Each one of the participants has various information that is loaded onto the system that can be accessed by other people. For example, health plans or lab results or other aspects of clinical information can be shared among providers."

The academy plans to partner with the OSMA and the Columbus Medical Association to offer accredited statewide credentialing services pending the NCQA accreditations. — *Jan Leibovitz Alley*

Take Action

"From the county files..." is designed to show how county medical societies are identifying and responding to issues in their area with programs and activities that you may wish to borrow for your county. If you would like more information about any of the programs mentioned here, contact Russell Dean, Executive Director, Academy of Medicine of Cincinnati, (513) 421-7010.

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OSMA's 1999 Annual Meeting



OSMA President-elect Walter J. Wielkiewicz, MD, Zanesville, (center) takes time to listen to the concerns of OSMA delegates.



Daniel Handel, MD, Lake Milton, (left) chair of the Ohio Political Action Committee, recruits another delegate for OMPAC.



Immediate Past President Lonce A. Talmage, MD, Toledo, says the saber presented him by the OSMA was used to rally troops during the Civil War, and will serve now to rally the house of medicine.



Delegates listen attentively as resolutions are proposed and debated before the entire House.



Teresa Long, MD, and Karen King, MD, Tenth District delegates, take a moment to confer before the opening of the House.

Practice Tips



BWC policy change

MCOs need alternate plan if they deny treatment

Managed-care organizations can no longer simply deny treatment. Now they must produce an alternate treatment plan and identify outcomes if they expect to be reimbursed by BWC.

Managed-care organizations that are in the dispute resolution process can no longer simply deny treatment. Now, they must produce an alternate treatment plan if they expect to be upheld by BWC.

The Ohio Bureau of Workers' Compensation (BWC), in its Alternative Dispute Resolution process, may overturn treatment denials made by managed-care organizations (MCOs). In those cases where the MCO fails to obtain a documented plan to provide

case management or a plan of care; or fails to obtain identification of outcomes, BWC will authorize the requested treatment.

The new policy emerged after a review of the BWC's alternative dispute resolution process. The review uncovered several problems including poor documentation, excessive time delays, and inconsistent medical management strategies by MCOs.

"This new policy is a way to encourage the MCOs to communicate with physicians more effectively," says OSMA Ombudsman Services Director Bill Fry. Nancy Gillette, JD, OSMA Division of Legal Affairs, adds: "It is targeted at plans that are denying treatment yet not working with the physician to develop an appropriate treatment plan."

According to Tina Kielmeyer, the bureau's Director of Policy, the alternative plan must be prepared in collaboration with the treating physician. "In no way does this policy mean that the MCO may dictate what treatment the physician is to use," she says. "The plan is to get the MCOs to pick up the phone and work with the physician to identify an alternative treatment that's agreeable to both."

The policy is expected to cover only a small number of cases where communications between MCOs and physicians seem to be lacking. It applies only to those cases that have gone to the bureau's Alternative Dispute Resolution process. It does not apply to those cases where treatment plans are initially denied by MCOs. ■

Take Action

If you have questions about this change in the BWC's alternative dispute resolution, please call the bureau's Health Partnership Program Information Unit, (800) 644-6292. Press 4 then 2. OSMA members may also contact the OSMA Ombudsman Services Department or the Division of Legal Affairs, (800) 766-6762, for help.

Beware: BWC steps up provider fraud scrutiny

Count the Ohio Bureau of Workers' Compensation as the latest government agency to scrutinize providers for fraud and abuse.

For the first time this March, the BWC's 21 field offices for special investigations turned its attention on the bureau's 50,000 certified health-care providers, looking for instances of fraud and abuse. The idea, says the bureau's director of investigations in a recent article in *Business First*, is to double the share of caseloads devoted to health-care provider fraud to about 15% over the next year. The reason? "Our exposure on the health-care side is much greater in terms of what (providers) can bill us," he said.

A new data warehouse, launched last October, allows BWC investigators to focus on doctors with unusual billing histories. They also have started to check providers' billing records by calling patients to see if they received the treatment specified on the record. Another target: bills that are dated on Sundays and holidays. ■

OSMA Ombudsman

Delays on crossover claims explained

Having problems with your crossover claims? If so, you're not alone. The OSMA Ombudsman Department says the state is not processing these claims on a timely basis, and, worse, physicians' offices are hassled as a result.

For example, in order to obtain reimbursement, physicians whose crossover claims exceed 60 days are now forced to file an additional (paper) claim to Medicaid, using the 6780 Medicaid claim form, in order to validate that the original claim was filed.

When the OSMA Ombudsman contacted the Ohio Department of Human Services (ODHS) about the matter, the Medicaid office offered the following explanation:

"During July through November 1998, the ODHS experienced automatic Medicaid/Medicare crossover tape problems. The tape issues were resolved and tapes were recreated and run in December 1998. This problem was described in the Nov. 4, 1998 Remittance Advice Notice, and in the March 17, 1999 Remittance Advice, the ODHS repeated that a staff reduction had impacted its capability to process all hard copy claims in a timely manner."

However, the department now states that it has no backlog of Nationwide (Medicare) tapes, and is processing them on a weekly basis. There are no crossover tape delays, the ODHS adds — only delays in hard copy crossover claims.

Physicians whose claims do not automatically cross over from Medicare to Medicaid should contact the department's Provider Enrollment Unit to verify the accuracy of the Medicare/Medicaid cross-reference file. ■

Take Action

If you have questions, or need more information on this subject, contact the OSMA Department of Ombudsman Services, (800) 766-6762.

Your Practice Guide

Do you need to hire a deaf interpreter for your office?

Whether or not you need a qualified interpreter in your practice depends on your patient and the type of information you need to convey.

The American with Disabilities Act (ADA) requires physicians (among others) to provide "reasonable accommodations" to ensure that disabled individuals have access to goods and services, and are not treated differently from others. Does that mean you must hire a "qualified" deaf interpreter for your office if you have nonhearing patients?

In determining if you need a qualified interpreter ask:

- How important is the information I need to convey? If your deaf patient is required to make an informed decision about a major medical

procedure or surgery, or you need to explain some complex issues, then it might be a good idea to enlist the help of a qualified interpreter. If the visit is a routine office visit with an established patient, the use of pen and paper, a word processor or communication through a family member may provide reasonable alternatives. If the patient wishes to communicate with you through a family member, remember that the patient's right to confidentiality must be considered.

- Will communications with the patient be impaired in any way? Always consult with your deaf patients (preferably in advance of appointment dates) to find out how the patients best communicate. Some deaf persons do not communicate effectively by lip reading or the use of written materials. In those cases, qualified interpreters should be provided.

- Has the patient requested a qualified interpreter? If so, then you

need to accommodate the request if you are able to do so. The law states clearly that, when deciding which auxiliary aids or services to provide, the physician must allow the patient to determine which aid or service they are most comfortable, and give "primary consideration" to that request. You must honor the choice, unless you can demonstrate that another equally effective means of communication is available or that use of the means chosen by the patient would fundamentally alter the nature of the service being provided, and would place an "undue burden" on your practice.

If you must hire a qualified interpreter for a deaf patient, you are prohibited, by law, from charging the patient for the provision of that service. However, small businesses (those with gross receipts of less than \$1 million and fewer than 30 employees) may deduct 50% of their costs over \$250 and less than \$10,250 to comply with



the auxiliary aids and services provisions. ■

Take Action

This information is from the OSMA's legal fact sheet on the Americans with Disabilities Act, which is available to OSMA members free of charge. You'll find the fact sheet on the OSMA Web site (look under hot news.) Or order a copy by contacting the Ohio Medicine reader response line (800) 766-6762, Ext. 6580, and ask for item #12-99.

In liquidation, as in practice, patients come first

Whether you're retiring or changing careers, you need to pay attention to details as well as patients, when you close your practice.

If you're a solo practitioner and liquidate your practice, you must notify patients well in advance of locking the door. "There are both legal and ethical prohibitions against patient abandonment," says Andrew Berger, a partner with Katz, Teller, Brant & Hild in Cincinnati. "You can't just close up shop and do nothing more."

Tell your patients in writing of your intention to leave the practice – the OSMA recommends that you use certified mail. Ask patients to let you know, also in writing, how they want you to handle their records, whether to transfer them to another physician

or send them directly to the patient. If, instead of closing the practice, you plan to turn it over to another physician, send your patients a letter of introduction and, assuming you are comfortable with doing so, recommend that they continue care with that practitioner. Should they choose against transition to your recommended physician, offer them the same options for acquiring their records.

"For those patients who don't respond," Berger says, "the doctor has a difficult problem in dealing with where to put the records." One solution, albeit an expensive one, is to keep the records in storage. Another is to give patients a deadline for claiming their records and inform them that you will no longer keep records after that date. "I don't recommend that," Berger says.

Most physicians prefer to leave their patients, and their patients' records, in the care of another physician. "Usually there's somebody who, in exchange for the burden of maintaining the records, is willing to get the first crack at continuing the patient relationship," Berger says.

Here's more to think about if you liquidate:

- **Employees and employee benefits.** Give your employees enough time to find other jobs – the OSMA suggests three months' notice. Notify all insurance companies that cover your employees; federal law requires that insurance companies allow employees to continue their health insurance for a period of time.

- **Drug disposal.** If you plan to discontinue your medical license, you must cancel your registration with the

Drug Enforcement Administration (DEA). You also must return controlled substances to the supplier, transfer them to another DEA registrant, or dispose of them according to instructions from the DEA or the Ohio Board of Pharmacy.

- **Taxes.** Closing down a corporation is a taxable event. Most professional corporations have few assets. Berger says, so chances are your tax liability will be low. – *Jan Leibovitz Alroy*

Take Action

For more information about closing your practice, contact Andy Berger, partner, Katz, Teller, Brant & Hild (513) 721-4532, or OSMA's Division of Legal Affairs, (800) 766-6762.

Your Practice Guide

Pain rules

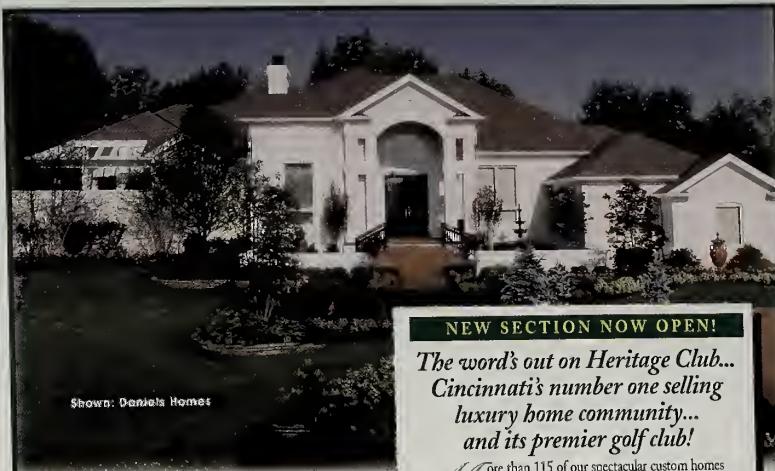
Need an addiction-medicine specialist?

Ohio's new pain rules suggest that physicians consult with an addiction-medicine or substance-abuse specialist if they suspect their patients may be suffering from addiction to their pain medication, or are abusing drugs. The other option is to refer the patient to the specialist.

If you don't know any specialists in this area the Ohio Physician Effectiveness Program (OPEP) is probably your best resource for names. If you need to consult or refer a patient who is suffering from chronic benign pain and who may be addicted, or who may be abusing drugs, contact OPEP at its Columbus office, (614) 841-9690 and ask for recommendations to specialists. ■

Deadline nears for Workers' Comp

Physicians interested in participating in the year 2000 Workers' Compensation Group Rating Program have until July 15 to apply to take part in the feasibility study to determine your projected premiums for the upcoming program year. Thousands of OSMA members participating in the current program will reduce their premium payments by as much as 50%. Signing up for the feasibility study does not obligate you to participate in the program. It only allows the Ohio Bureau of Workers' Compensation to release pertinent information to Gates McDonald, the OSMA's program administrator. To learn more about the plan, check the box on the response card in this issue of *Ohio Medicine* and an application will be sent to you. ■



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Your Practice Guide

Y2K preparedness

Will you be legally liable for Y2K problems?

The insurance industry is moving quickly to exclude coverage of Y2K liability. You may be at risk if you don't act now to protect your practice.

Now is the time to determine what your legal liability risks may be if your Y2K compliance efforts are ineffective or inadequate. The following information, excerpted from the AMA's *The Year 2000 Problem: Guidelines for Protecting your Patients and Practice*, is designed to help you protect your practice. The sooner you take these steps the better.

Step 1: Inventory your current policies

Your current policy may provide coverage now, but it depends on the policy:

- Commercial property insurance (damage to property)

Varieties here include the basic, broad and special forms. Basic and broad forms are unlikely to cover Y2K problems unless the problem leads to a covered loss (i.e., fire, sprinkler leakage, etc.) Special forms are your best bet. They provide the broadest coverage. Still, even these may be problematic because most policies require physical loss of property. Y2K may result in damage to data, not property itself.

- Commercial property insurance (business interruption)

Many such policies are restricted to complete business standstill, not to reduction in productivity as is likely to occur with Y2K problems.

- Commercial general liability insurance

Damages caused by Y2K problems may or may not be covered, depending on the policy's language. Generally, this insurance pays for damages resulting from bodily injury,

personal injury or property damage that is neither expected nor intended by the insured. Such policies also entitle the insured to a defense to suits brought for liabilities covered by the policy.

- Professional errors and omissions insurance

This professional liability coverage protects the insured after failure to comply with the profession's standard of care. Such coverage may apply to malpractice, even if that act were due, in part to a Y2K problem.

- Directors and officers liability insurance

This is specific to those individuals who hold titles in professional corporations or any other proprietary or nonprofit corporation. Information is covered at length in the AMA handbook. See "Take Action" on how to order a copy.

Step 2: Identify any specific Y2K exclusions or other limitations.

The insurance industry is moving quickly to exclude coverage of Year 2000 liability. Arguments insurers can use for not covering your claim:

- 1.) "Losses must be fortuitous."

Insurers might argue you knew about the potential for failure. Your response should be that you were aware of the problem and took reasonable efforts to make your systems compliant. After that, you had no reason to expect any Y2K-related damages. Be prepared to prove your defense.

- 2.) "You must disclose Y2K exposure."

The insurer may try to deny coverage by saying you knew of Y2K problems that could occur but failed to disclose them when you applied for the policy. Your argument: you were not aware that your system or product had a Y2K problem at the time of application, if that's the case.

continued on next page



exhibit A:

Adhesive bandage, which plaintiff alleges defendant pulled rapidly from skin, violently tearing three hairs from plaintiff's arm, which resulted in severe shock, trauma, disfigurement, chronic debilitating pain and permanent psychological damage.

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Liable for Y2K

continued from page 20

Be truthful and provide accurate information to your insurer when seeking a policy.

3.) "Claim notices have deadlines." Insurance policies require that notice of potential claims be given within a specified time period. In the case of "claims made" policies, such notice must be given before the policy has expired. Policies can also restrict the period during which you can file a lawsuit against the insurer if you disagree with how the insurer handled your claim. Pay heed to all these "deadlines" when filing claims.

4.) "You have an obligation to mitigate potential Y2K damages." Inherent in every insurance policy is the insured's duty to mitigate or prevent losses. It's an argument an insurer could use to deny coverage if your practice had not undertaken reasonable Y2K remediation efforts.

In other words, the insurance industry has anticipated Y2K problems, and has prepared several exclusionary endorsements that carve out Y2K-re-

lated failures from coverage. Warning: Some of these exclusionary endorsements may be added to your current policy during renewal time. By paying the renewal premium, you have indicated your willingness to accept the change, so read your policies carefully before renewing them.
—Carol Larimer

Take Action:

To order a copy of the AMA's *The Year 2000 Problem: Guidelines for Protecting Your Patients and Practice*, contact the AMA Answer Center, (800) 621-8335. Cost to AMA members is \$25, \$100 to nonmembers. Members can also download the guidelines from the AMA Web site, www.ama-assn.org/nol-mo/y2k/protguid.htm at no cost.

Medicare billing seminars in progress

The OSMA is once again offering Medicare billing seminars to members and their office staffs. The half-day program addresses topics such as: fraud and abuse; E&M services; Y2K concerns; the HCFA 855 form; and proper billing guidelines in addition to the latest updates on Medicare billing and coding.

The seminars will be offered throughout the state during July. The schedule is as follows: (Each half-day session is offered both a.m. and p.m. except where noted.)

June 8	Cambridge, Holiday Inn Cambridge
June 9	Canton, Canton Hilton
June 16	Cincinnati, Holiday Inn Eastgate
June 17	Dayton, Dayton Convention Center
June 22	Elyria (1/2 day a.m. only) Holiday Inn Elyria
June 23	Mansfield, Comfort Inn North
June 29	Cuyahoga Falls, Sher-

ton Suites
June 30 Cleveland, Holiday Inn Independence
July 14 Youngstown, Holiday Inn Metroplex
July 15 Columbus (1/2 day p.m. only), OSMA Headquarters
July 21 Perryburg, French Quarter Hotel
July 28 Columbus, OSMA Headquarters

Take Action

If you would like to register for the seminars, or need more information, contact Cothy Sonnholter, OSMA Department of Ombudsman Services, (800) 766-6762, Ext. 6759.

Ohio Medicine

A Publication of the Ohio State Medical Association

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Ohio Medicine (ISSN 0892-2454/USPS 405-200) is published monthly for \$40 a year by the Ohio State Medical Association, 3401 Mill Run Drive, Hilliard, Ohio 43026. Periodicals postage paid at Hilliard, Ohio and at additional mailing offices. POSTMASTER: Please send address changes to *Ohio Medicine*, 3401 Mill Run Drive, Hilliard, Ohio 43026.

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Colleagues

Newsmakers

DANIEL BLACK MD, Gallipolis, was recently inducted into the Ohio State PM&R Society. "Our goal is to obtain membership activity at the state level and to network with the American Academy of PM&R and the Ohio State Medical Association." Dr. Black is currently the medical director of in-patient and outpatient rehabilitation services at Holzer Clinic and Holzer Medical Center.



Mary Ann Everhart-McDonald, MD

MARY ANN EVERHART-MCDONALD, MD, Columbus, was recently recognized by

Mary Ann Everhart-McDonald, MD

Portrait

Willoughby Heights plastic surgeon Ronald J. Taddeo, MD is a true Renaissance man whose hobby turns medicine into both art and science.



Ronald J.
Taddeo, MD

As a plastic and reconstructive surgeon, Ronald J. Taddeo, MD, has affected many lives within his community. Yet it is his keen interest in history and the arts which extends that influence beyond the operating room.

Combining a love of history with his writing and photography abilities, Dr. Taddeo creates slide programs, complete with a pre-recorded script, to educate and entertain varied audiences.

Dr. Taddeo is also the historian and a past president of the Lake County

the U.S. Olympic Committee drug testing program for her participation as a Crew Chief for the past 14 years. In June of 1998 she was a member of the National Summit on Drug Free Sports held by the USOC. Recently, she was selected to be one of three physicians on the National Federation of High School Associations' Sport Medicine Committee.

GEORGE HARDING, MD, Columbus, chair of Harding Medical Center, honored the work of two individuals by naming two campus facilities in their honor. The administration building was named the James L. Hagle Administration Building, and the education and conference facility, located in the administration building, was named the Harrison S. Evans Education and Conference Center. Dr. Harding said both individuals made contributions to enhance the clinical

and educational programs offered at Harding. "Much of the success and reputation of our programs and services can be credited to James Hagle and Dr. Harrison Evans. It is through their guidance that Harding is known today as a leader in the delivery of behavioral health care."

JOHN HINTON, DO, Cincinnati, has been named medical director and vice president of medical management of Preferred Physician Partners. Dr. Hinton will be responsible for coordinating medical management and professional development programs in health system-affiliated and free-standing physician organizations. This includes assisting physicians to implement quantifiable measures for ongoing performance monitoring to assure continual improvement of medical quality, cost effectiveness, and service.



Obituaries

AHMET TURGUT CABİ, MD, Warren, Bursa Tip Fakültesi İstanbul Üniversitesi, Bursa, 1957; age 67, died March 17, 1999.

ABIGAIL SYLVIA ENGLENDER, MD, Cincinnati, Ohio State University College of Medicine, Columbus, OH, 1941; age 83; died Feb. 14, 1999.

DONALD L. GAMBLE, MD, Bowling Green, University of Pennsylvania School of Medicine, Philadelphia, 1941; age 82; died Feb. 15, 1999.

HAROLD HIATT, MD, Cincinnati, University of Cincinnati College of Medicine, Cincinnati, 1946; age 74; died March 2, 1999.

LESTER G. PARKER, MD, FACS, Sandusky, Ohio State University College of Medicine, Columbus, OH, 1940; age 84; died Feb. 16, 1999.

HAROLD PESCOVITZ, MD, FACS, Boynton Beach, FL, State University of New York at Buffalo School of Medicine, Buffalo, 1947; age 74; died Feb. 15, 1999.

ZELDA E. HEINEY RATHWEG, MD, Centerville, University of Cincinnati College of Medicine, Cincinnati, 1941; age 87; died March 5, 1999.

PETER SAUNDERS, MD, Walnut Creek, Orvosi Fakultas Pecs Tudomanyegyetem, Pecs, 1937; age 86; died March 4, 1999.

RICHARD C. SINGERMAN, MD, Lakewood, Case Western Reserve University School of Medicine, Cleveland, 1947; age 79; died March 4, 1999.

HARLAN WILLIAMS, MD, Loveland, University of Cincinnati College of Medicine, Cincinnati, 1957; age 68; died March 2, 1999.

Focusing on more serious accomplishments within the field of plastic surgery, Dr. Taddeo presented a medical paper at the University of Bologna, Italy, on history and medicine.

In what Dr. Taddeo calls his renaissance art/medicine presentation, he "tried to tie art, medicine and science together." Juxtaposing images copied from art books and medical texts, he gives the viewer a historical perspective of the art and medical and scientific discoveries of the Renaissance era.

For the past nine years, this former journalism major has written articles on food, wine, travel, language and culture for *La Gazzetta Italiana*, a publication of the Cleveland-area Italian community. Since his recent retirement, Dr. Taddeo says he'll have more time for his artistic endeavors. "Writing is a vocation I plan to pursue more seriously now," he claims. —Pamela J. Willits

TDC

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July 1999

Ohio Medicine

Cleveland Academy drops its lawsuit against the OSMA

In addition, the Academy of Medicine of Cleveland decided to discontinue its legal pursuit to remain affiliated with organized medicine in Ohio.

1999, when a violation by AMC prompted the OSMA to revoke the county society's charter for a second time.

A substitute resolution offered on the floor of the House of Delegates asked that AMC be encouraged to apply for an OSMA charter once it had met seven conditions – including compliance with OSMA bylaws and suspension of AMC's lawsuit against the OSMA. The House decided to refer that resolution to the OSMA Council.

"These recent actions by the acad-

emy clearly indicate that it has chosen to disassociate itself from the federation of organized medicine throughout Ohio and focus solely on the local issues impacting physicians," says Dr. Utlik. "The OSMA and its new component organization, the Cuyahoga County Medical Society, on the other hand, are working together to address the broad scope of challenges – local, regional and statewide – impacting the physicians, their practices and their profession." ■

3



Ohio's new DNR rules are in effect. Comfort Care and Comfort Care Arrest are the two orders you may now write for your do-not-resuscitate patients.

9

Alternative medicine modalities are employed by some physicians who come to this mode of therapy through their patients, or through their own circumstances.

11

OSMA's group practice directory provides an updated look at 247 group practices in the state and gives you a thumbnail look at how they're structured.

17

Do you need help with your managed-care contracts? One of the benefits of OSMA membership is a free contract review service, offered through the Division of Legal Affairs.

18

When a patient presents with multiple conditions, diseases or problems, coding can be confusing. There are some general rules to follow, however.



Y2K: Are you ready?

If not, the OSMA is developing guidelines that can help you prepare your practice for any potential problems created by year 2000 computer glitches.

If you think Y2K won't affect you, think again. No matter where you practice, what or how (in solo or group practice), your business may be at risk, depending on what happens when Jan. 1, 2000 rolls around.

The OSMA wants to help you make your practice ready for Y2K.

"We're in the process of developing general guidelines and a directory of contacts with Ohio-specific names and Web

sites that will help you prepare your practice for any potential Y2K problems," says Todd Baker, OSMA director of Medical Economics and Advocacy.

The OSMA's *Y2K Readiness Guide* will provide information that will help you:

- Identify problem areas;
- Determine what to do (who to contact, etc.);
- Test your systems;
- Implement changes and updates; and
- Draw up a contingency plan.

Information will be drawn from Y2K help kits produced by the AMA and the Health Care Financing Administration, as well as from other sources.

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Bills, Laws & Rules

Understanding the new DNR rules

The do-not-resuscitate guidelines took effect May 20, and were outlined briefly in the last issue of *Ohio Medicine*. Here's more information on the new DNR rules.

What are the two new orders?

There are two types of standardized DNR orders:

- **Comfort Care.** A dying person receives any care that eases pain and suffering in the final days of life, but no resuscitative measures to save or sustain life; and
- **Comfort Care-Arrest.** A dying person receives treatment, including resuscitative efforts if necessary, until the time he or she experiences a cardiac or respiratory arrest. Once an arrest is confirmed, all resuscitative and treatment efforts are withdrawn, and Comfort Care alone is initiated. These orders will be implemented by all health-care personnel in accordance with the standardized protocol also found in the rules.

Who may write a DNR order?

Only physicians and advanced practice nurses (APNs) are authorized to write a DNR order. The DNR Comfort Care order form is available on the Ohio Department of Health Web site. Here is how to access the forms:

- 1.) Go to the Web site, www.ohio.state.oh.us/dnr/dnr1st.htm (Or link to it from the OSMA Web site, www.osma.org)
- 2.) Click on "Forms," then "Do Not Resuscitate Comfort Care forms."
- 3.) From there you may click on the order form; the DNR wallet ID card; or the DNR hospital bracelet insert.

When is a DNR order activated?

For a DNR Comfort Care patient, the protocol is activated when the DNR order is issued or the living will specifying no CPR becomes effective. For a

DNR Comfort Care-Arrest patient, the protocol is activated when the patient experiences cardiac or respiratory arrest. Cardiac arrest means no palpable pulse, respiratory arrest means no spontaneous respirations or the presence of agonal breathing. The protocol may be downloaded from the OSMA Web site.



For a DNR Comfort Care-Arrest patient, the protocol is activated when the patient experiences cardiac or respiratory arrest.

How should a DNR Comfort Care order be documented in the patient's record?

Document your patient's chart according to the policy of your office or the facility. You may wish to place a copy of the order in the patient's chart. The DNR order form is not mandatory. You may document your DNR order in any way you wish as long as it is consistent with the policy of the health-care facility if the patient is in one. The

form in the rules, however, allows the DNR order to be used as DNR identification. Over time, the form is likely to be commonly recognized as a DNR order, while other types of documentation may not be as easily identified.

Can the new DNR orders be changed or revoked?

Your patient may choose to revoke the DNR order at any time, or ask to change the order from DNR Comfort Care-Arrest to DNR Comfort Care. Physicians may revoke a DNR order, but you should be careful to determine what change in circumstances has necessitated the revocation. DNR orders can't be issued if they are contrary to reasonable medical standards or contrary to the wishes of the patient or a legally-authorized representative. If a DNR order is properly issued, the only reasons for revoking it would be that it is no longer medically appropriate, or the practitioner receives evidence that it is contrary to the patient's wishes.

Can I write a DNR order that varies from the new state standard DNR order?

Yes, you can write a DNR order that includes a different protocol, but this will not be a DNR Comfort Care order. The advantage of using the state standard Comfort Care order and protocol is that you automatically have limited immunity from liability.

How will DNR Comfort Care patients be identified?

Patients can be identified as DNR Comfort Care patients through the order itself, or through a wallet identification card or a hospital wristband. Patients will not be required to carry the ID card but if you are unable to

Any questions?

If you have questions about the state's new standardized DNR orders, contact Nancy Gillette, JD, OSMA Division of Legal Affairs, (800) 766-6762, Ext. 6767. The DNR protocol, approved by the Ohio Department of Health, is available on the OSMA Web site, www.osma.org. (See "Hot News.") If you would like a copy of the DNR Comfort Care form, you may download it from the ODH Web site as explained in the article. Also, in August, the OSMA will have available for members a packet of information about the new standardized DNR orders for physicians. It will include an order form, protocol, information sheets for physicians and material about the new DNR form that you can share with your patients. To pre-order a packet, contact Traci Benzing, Division of Legal Affairs, (800) 766-6762, Ext. 6765.

identify the individual as a DNR Comfort Care patient, then, in the absence of a definitive DNR order, you must, legally, make every effort to resuscitate the person. As with the order form, the identification cards and wristband inserts are available on the ODH Web site. (They may be down-loaded and copied. The identification cards are two-sided, so they will have to be assembled.)

Can a family member revoke the DNR Comfort Care order?

No, you must honor the DNR order you and your patient have agreed to. A family member can't revoke a DNR order unless the patient has a living will or advance directive which names a family member (or someone else) as an "attorney-in-fact" who is authorized to make health-care decisions for your patient. If that's the case, then that individual may be able to revoke the order. ■

New disciplinary guides set for CME violations

The State Medical Board of Ohio has adopted amendments, proposed by its Disciplinary Policy & Guidelines Committee, dealing with fines for CME violations.

One amendment puts in place a reprimand for those cases where the physician is in compliance, but didn't respond to the board's request for CME records in a timely fashion.

A second amendment says that if the physician has made up his or her CME shortage by the time the matter comes to the board, the physician will:

- receive a reprimand;
- be fined \$5,000; and
- be audited for the next two renewal periods.

The fine is standard, no matter what the circumstances. Previously, the physician would have had his license suspended for 30 days as a result of the violation. Now, a license suspension will depend on the physician. If a physician makes up the missing CME hours before coming to the board, he or she will be disciplined, as described above. There will be no license suspension. However, if the physician has not made up the missing CME hours prior to his or her board appearance, the license would be suspended until the shortage of hours is made up.

Finally, if during two subsequent renewal periods, the physician does not complete the CME requirement, there will be an additional \$5,000 fine and a minimum of 60-days license suspension.

The board has created a staggered license renewal system that has been described in past issues of *Ohio Medicine*. During the initial period of this system, CME hours are pro-rated in proportion to the length of time the license is valid (and depending on the licensee's last name.) You can find the dates of your license renewal cycle by checking your Ohio license wallet card. You may also check the medical board's Web site, www.state.oh.us/med to determine the number of CME hours required for renewal. From the board's home page, go to License On-line Lookup (you can search by last name

Medical Board Report

or by your license number.) *Ohio Medicine* also has available a chart that shows the revised CME schedule, as well as the number of pro-rated CME hours required for your license renewal. See "Take Action."

Board to proceed on educational initiative

Board President Anita Steinbergh, DO,

has prepared a rough outline for the educational initiative she hopes to launch as board president, and she has asked for the board's support to move forward with the project. The project, she explains, is to develop an educational tool that can be used by medical schools and postgraduate programs to educate young physicians on their responsibilities as licensees. The goal, says Dr. Steinbergh, is to prevent future physicians from coming before the board on disciplinary matters. The Ohio University College of Osteopathic Medicine will participate in the project by providing input and financial help. Dr. Steinbergh says the deans of other medical schools in Ohio will

be involved as well. OSMA Immediate Past President and board member Lance Talmage, MD, recommended that OSMA input also be sought for the project, since the board uses AMA principles of ethics in determining ethical issues brought before it, and the OSMA Committee on Ethical and Judicial Affairs provides expertise on these principles.

Y2K shouldn't affect licensees

When it comes to the Y2K problem, the medical board is in compliance, at least as much as it can be. Executive Director Ray Bungarner reports that

continued on page 6

HB 4: Ensuring legal liability clout

Some Ohio physicians may have been dismayed last month, when HB 4, Governor Taft's Patient Protection bill, sailed through the Ohio House and started through the Ohio Senate – without a much-discussed provision making HMOs liable when treatment denials result in harm to the patient. At press time, the bill was expected to be voted out of the Senate by the end of June and be sent to the governor for his signature – without the liability provision.

However, the Ohio State Medical Association has said all along that there are a number of ways to assure accountability in managed care, even without a liability provision like the one that was considered and subsequently dropped from HB 4.

The OSMA has always been on record as a strong supporter of HMO liability. "But now the focus has shifted away from using the courts to resolve disputes between HMOs and patients," says Tim Maglione, OSMA director of Legislation. "The current case law provides liability on the HMOs and a statutorily-created right to sue may not be necessary," says Maglione. He explains that accountability for HMOs is already established within the common law.

The new focus of the bill (soon to be law) is on patient-requested, external re-

view. "External review is the process where a neutral, independent, and objective medical expert will resolve disputes regarding medical necessity issues." Three key concepts related to the decision are: independent, objective and binding, says Maglione.

Independent means that the external review organization is prohibited from having any financial ties to the HMO. "The HMO is expressly prohibited from choosing the actual medical expert who conducts the review," explains Maglione.

Objective requires that the medical expert be a clinical peer. That means he or she must be a practitioner within the specialty being scrutinized so that "like-specialty review" is assured. Further, Maglione states, "Independent means that the medical expert is required to use 'evidence-based decision making.' This means the expert is obliged to refer to findings, studies, research from government agencies and nationally recognized organizations, such as the National Institutes of Health, National Cancer Institute, National Academy of Science, and similar resources."

Finally, binding is important because if the expert says yes, this is a recommended treatment, the HMO must do it. Says Maglione, once the binding mediation is completed, there

are no more appeals; the mandated, appropriate action must be taken.

In the current language of HB 4, however, the path to external review must first lead through the internal appeals processes built into the HMO's normal structure. "Current law required specified time frames for this activity," Maglione comments, "so it won't go on forever."

Another strong point about the current version of the bill is that the process of external review will be available at no cost to the patient.

Further general provisions of the bill include:

- Direct access to ob-gyn care for women without going through an HMO gatekeeper/referral step.
- Free telephone lines to HMOs' service desk staff who will explain the HMO policy and the health plan to members.
- Tax deductions for some health-care expenses, including purchase of some types of health-care insurance.

"The bottom line is that HB 4 now assures accountability because it allows disputes to be resolved between the health plan and the patient via a neutral health-care expert," says Maglione. Accountability is why the OSMA supports the new version of HB 4. — Yvonne H. Barry

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Medical Board

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only one program in its control has not yet been tested, but the staff believes it is in compliance. The latest date for testing by other state agencies is Nov. 1.

Managed care complaints

Of the number of complaints the State Medical Board receives each month, how many relate to managed care? The board's managed-care committee is interested in those statistics, so the board's staff has started to gather information that can provide the committee with answers. In addition, the committee is also having discussions about some of the managed-care plans that put physicians at risk of discipline because of financial incentives. ■

Take Action

If you would like a copy of the board's staggered license renewal schedule, and the CME requirements, contact the Ohio Medicine reader response line (800) 766-6762, Ext. 6850, and ask for item #17-99.

Y2K:

continued from page 1

"There will be lots of information and data, and we'll make it as state-specific as we can. It will serve as a good resource, giving you, in most instances, the specific number and Web site to contact if your practice may have a problem," says Baker.

The guidelines are expected to be completed by the end of the month, and will be sent to members upon request. ■

Take Action

If you would like to receive a copy of the Y2K Readiness Guide for Ohio physicians, contact the Ohio Medicine reader response line, (800) 766-6762, Ext. 6850 and ask for item #12-99. The handbook will be available at the end of the month. If you have other Y2K questions, contact Todd Baker, OSMA Division of Public Affairs, (800) 766-6762, Ext. 6734.

Duty-to-warn bill passes with amendments

House Bill 71, the bill that addresses a mental health professional's duty to predict, warn of, or take precautions to prevent the violent behavior of mental health patients, has passed the Senate, but not without a couple of amendments. One amendment requires professionals hearing threats of violence to determine how he or she can eliminate (not just minimize), through treatment, the prospect of a threat being carried out before avoiding the other options listed in the bill (i.e. hospitalizing the patient or notifying police.) The second amendment says that if the professional decides to proceed with treatment rather than exercise the options listed, his or her decision must be backed by a second opinion. The OSMA has actively supported this bill. HB 71 is now en route to the governor.

Bills passed:

July is "obesity awareness" month...**Senate Concurrent Resolution 9** passed in time to name July 1999 as "Obesity Awareness Month." SCR 9 urges the Ohio Department of Health, as well as the medical community, to recognize obesity and treat it. The OSMA took a neutral position on the resolution.

These health-care bills have also passed...**House Bill 261**, health insurance liability, repeals the scheduled repeal of the laws that establish qualified immunity from civil liability for health-care providers who provide free services to indigent patients. It passed the House and is now in the Senate. **House Bill 148**, handicapped parking, also passed in the House. This bill increases the penalties for a violation of the special parking privileges established for persons with disabilities, and makes changes in the application process for removable windshield placards. HB 148 is now in the Senate. On its way to the governor is **House Bill 16**, health-care study, which creates a task force to study consumer access to preferred provider plans, point-of-service plans and other open panel plans for health-care coverage.

Bill tracker

Bills introduced:

"Any-willing" pharmacy bill reintroduced...A bill that died last session has surfaced again. **House Bill 307**, sponsored by Rep. Bryan Williams (R-Akron), would allow consumers to select and use their own pharmacies if the pharmacies meet the conditions set by insurance companies. The OSMA has not yet considered this bill.

Liability created for partial birth infanticide...If **House Bill 351** passes, there would be a new liability created if a child dies as a result of a "partial birth infanticide." The bill allows certain persons to bring a civil action for damages when such incidents occur. Sponsored by Rep. Jerome Luebbers (D-Cincinnati), HB 351 also repeals the prohibition against performing a dilation and extraction procedure on a pregnant woman, as well as the related civil action.

Alternative medicine not grounds for board discipline...If a doctor uses alternative, integrative or complementary medical treatments, is that grounds for medical board discipline? Not if **Senate Bill 125** passes. The bill, sponsored by Sen. Charles Horn (R-Kettering) says that use of any alternative therapy by a medical doctor, osteopath or podiatrist is not, in itself, grounds for discipline by the State Medical Board of Ohio.

Will HMOs have to let providers apply for contracts?...**Senate Bill 126**, sponsored by Sen. Gregory DiDomenico (D-New Philadelphia), would require HMOs to give an application to any health-care provider who wants to enter into a participation contract with them. The intent is to relieve the frustration of patients who live in counties where there are no providers affiliated with their insurer. SB 126 requires insurers to respond in 90 days to physicians who apply for contracts, and to state their reasons for an adverse decision. The HMO would also have to

allow the applicant to work on his or her shortcomings, given by the HMO, so a contract may be secured in the future. The OSMA has not yet considered SB 126.

Bills update:

Bill repealing hepatitis vaccine requirement dies...Thanks to the work of OSMA members and other health-care professionals, **House Bill 200**, which would have suspended the requirement that children entering kindergarten be immunized against hepatitis B, was killed in committee. Two amendments were offered to salvage part of the bill, including one that would allow parents to receive exemptions for their children if they assumed responsibility for possible future infection, but both amendments were defeated. The bill's opponents had shown that, in those states that required immunization, the rate of hepatitis B among children had declined significantly. The OSMA had actively opposed the bill.

Medicaid providers to receive increase...Thanks to the efforts of the OSMA, the state's budget bill will increase funding for certain Medicaid providers to the tune of about \$125 million...\$36.4 million beginning July 1, and an additional \$99.2 million in the year 2000. Also, these providers will receive an annual rate adjustment beginning July 1, 2001, based on inflation.

Cardiac cath safety decision due by November...Between Nov. 1 and Nov. 30 this year, the Ohio Department of Health (ODH) will need to complete its study on whether or not it's safe for health-care facilities to perform cardiac catheterizations without on-site open-heart surgical backup, and file a new rule on the matter. The ODH wanted to wait until June 2000 before making its determination, but moved up the date after meeting with the OSMA, OHA: the Association for Hospitals and Health Systems, and state lawmakers. The OSMA was opposed to the 2000 date, but is in favor of the new November deadline. ■

Entertainment or Endangerment?



Things are not always as innocent as they seem. What physicians and surgeons once trusted as the most basic of safety precautions, the Latex glove, has in some cases turned out to be a life-altering threat. Victims of Type I Latex poisoning face dangerous exposure daily from such seemingly harmless sources as a child's tub toy. This can result in devastating career and lifestyle changes - and in some instances, even death!

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Regulatory Update

Moratorium on cardiac cath rules continues

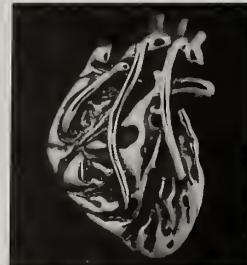
The budget bill currently in committee would provide for low-risk cardiac cath in hospitals without open heart backup if they have a minimum of 100 beds and are located in counties with populations ranging from 30,000 to 90,000.

The Senate Finance Committee is considering an amendment to Ohio's biennial budget, added in the House, that includes provisions for low-risk cardiac catheterization services in certain hospitals that have no on-site heart surgery programs. It's too soon to tell if that language will remain when the budget goes before the Senate, but if it does it may conflict with the current cardiac cath rules of the Ohio Department of Health (ODH).

Rules adopted by the ODH in March 1997 limit both low- and high-risk diagnostic cardiac cath and therapeutic cardiac cath to hospitals that also have on-site open heart surgery. An exception was made for low-risk service established before March 20, 1997, when the quality rules went into effect.

The budget bill currently in committee would provide for low-risk cardiac cath in hospitals without open heart backup if they have a minimum of 100 beds and are located in counties with populations ranging from 30,000 to 90,000. Based on Ohio Hospital Association figures, there are 24 such hospitals, says Nancy Gillette, OSMA's regulatory affairs counsel.

The 1997 rules were not intended as the final word but rather placed a moratorium on the establishment of new cardiac cath services until the director of ODH could determine the safety of performing low-risk diagnostic procedures in hospitals that have no



backup open heart services. That determination and an updated rule were expected May 1. Last fall, however, ODH, along with other interested parties, requested that the moratorium continue for two more years. Although OSMA argued against the extension, ODH was given an additional six months, until November.

Gillette can't predict what action ODH's new director, Nick Baird, MD, might take in November. "We don't know," she says. "It's too soon to say what action the department might take." Dr. Baird is expected to include in his consideration the positions of the American College of Cardiology (ACC) and the American Heart Association (AHA). The two organizations have issued a joint statement against performing cardiac catheterizations in free-standing facilities. — Jan Leibovitz Allay

Take Action

For more information, contact Nancy Gillette, OSMA's regulatory affairs counsel, (800) 766-6762, Ext. 6767 or the Ohio Department of Health, (614) 466-3543.



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Indepth Report

Alternative medicine

Why doctors embrace new modalities

When he started his college medical sociology course, says Peter Brian Dane, DO, "I thought doctor meant MD and MD meant doctor." The course, which introduced him to osteopathic medicine, shaped his outlook and his career.

"Here was a whole area of medicine that I knew nothing about except mythology and innuendo and misinformation," says Dr. Dane, now curriculum dean at Ohio University College of Osteopathic Medicine in Athens. "Once I realized that, and had that experience, I could not turn around and say there are (only) two main forms of valid medicine practiced in the United States."

Curriculum revision

OUCOM is undergoing a curriculum revision that will allow the college more flexibility in introducing new material, Dr. Dane says, including information on complementary, or alternative healing. "Part of the structure that has emerged involves case studies," he says. "It's relatively easy to tweak a case study to incorporate some element of alternative healing measures, just to drive the discussion. So taking someone who is hypertensive and using that case to discuss how hypertension develops and what its impact is on the body – it wouldn't take much to tweak the case to say that the patient has been taking some herbs or going to an alternative medicine practitioner."

The impetus for OUCOM to include at least the fundamentals of complementary medicine stems from a study, published in the Nov. 11, 1998 edition of the *Journal of the American Medical Association* that suggested that Americans visit alternative medicine practitioners more often than primary care physicians. "That was a pivotal point in the attitude that the medical profession as a whole took toward alternative medicine practitioners," Dr.

Dane says. "The numbers were there and the logic was there. Whether you agree with it or not, they're doing this, so it behooves you to find out as much as you can about what they're doing."

Bucking the system

Alternative modalities were not an accepted topic for discussion in the 1980s, when Therese Zink, MD, studied medicine. She had developed an interest in complementary therapies before she went to medical school, says Dr. Zink, associate professor in the department of family medicine at the University of Cincinnati. "My decision was whether to be an alternative healer or go to medical school. And I say that I decided to go to medical school because the only way to change the system, in my idealistic thoughts, was to go through it."

Dr. Zink co-wrote an article about herbal health products that appeared in the Oct. 1, 1998 issue of *American Family Physician*. Since then, she's been asked to do continuing medical education on herbs. And she works her knowledge into a course for third-year medical students. They love it, she says.

She doesn't, however, use complementary modalities in her own practice. "The reality is that the busyness of the schedule makes it pretty difficult to do that on a regular basis with my patients," she says. "I've never figured out how to integrate that. I have enough knowledge to help me know what the other systems have to offer patients. The more I do medicine, the more it's clear it doesn't have all the answers. I've referred people to chiropractors. I have encouraged people to think about acupuncture. I encourage patients to get a massage. I have asked patients if they want to consider herbs. When my conventional bag of tricks doesn't have a lot more to offer, then I think it can be helpful. Or if patients are looking for guidance, then I'll help them sort through that as well."

A new bag of tricks

It was patients' influence that convinced Frank E. Isabelle, MD, to incorporate complementary therapy into his practice.

Dr. Isabelle, former chair of the ob-gyn department at Grant Medical Center in Columbus, would prescribe Premarin to patients for symptoms of menopause, and many of them would return with complaints about headaches, bloating, weight gain and other side effects. "(Women) are more in tune with what's happening to them," he says, "and they're more assertive in their menopause age. Something's got to be better than what you're doing for me because I'm so sick of what you're doing for me." Patients showed Dr. Isabelle information about natural estrogens and progesterone. "As a scientist, I'm skeptical," he says. "I want to see studies to help me out. After due diligence with this thing, I've become convinced that this is another option that patients can (use) to manage their menopause."

"It has become clear to me throughout my career," says Henry F. Kenkel, MD, "that all of these holistic approaches are strongly based in developing a therapeutic relationship with the patient, communicating compassionate rapport, the kind of interaction that seeks to inform and empower the patient to self-help." Dr. Kenkel, a neurologist and psychiatrist, is director of the Franciscan Wholistic Health Center, on the campus of Franciscan Hospital in Mount Airy. It never made sense to him that a stroke patient, for example, "at the very time the patient was at a tender state," was given medication that would blunt the ability to learn. "I became very curious how to interact with these people where they were really hurting. It certainly was not adequate to throw psychotropic drugs at them, although sometimes that was helpful."

Dr. Kenkel has studied such alternative therapies as yogic metaphysics,

reflexology and acupuncture. He has psychologists and a nurse practitioner on the staff of the Franciscan health center, but he also has teachers of yoga, t'ai chi, and Feldenkrais and movement therapies.

"Models are largely driven by economics," Dr. Kenkel says. "I think that as a profession physicians have to become strong in emphasizing the importance of models of practice that allow for developing (holistic) relationships. Thoughtful physicians understand that care of patients is so much more than biomedical."

Economics of medicine

Drug therapies in particular have an economic basis, Dr. Isabelle says. "Most of the studies done on medications come from the huge pharmaceutical houses that make the drugs. There's no money to be made on natural products; you can't patent those things. You can't patent plants."

When he counsels his perimenopausal patients, Dr. Isabelle includes information on both the standard hormone replacement therapies and plant-based hormones. He encourages patients to find information on their own. "I'm proactive in helping them find the resources that they're going to need in the next couple of years," he says. "I also tell them, 'What I'm telling you now – if you come back next year, I may tell you something totally different, because that's just how knowledge is going.'"

Many physicians are uncomfortable with the idea of introducing new therapies into their practices, Dr. Isabelle says. "That's why they stick with Premarin – it's something we've known forever, and they don't like change. But our knowledge changes constantly. I do different surgical techniques now than I did 20 years ago. I do different therapies now than I did 20 years ago."

Dr. Isabelle understands physicians' reluctance to try unfamiliar therapeutic modalities. "My colleagues are very bright, very intelligent," he says. "They've just not had the exposure. No one's lifted their awareness." — Jan Leibovitz Alley

Take Action

For more information, contact Peter Brian Done, DO, (740) 593-2251; Frank E. Isabelle, MD, (614) 326-1000; Henry F. Kenkel, MD, (513) 853-5992; or Therese Zink, MD, (513) 558-4758.



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MICOA is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

OSMA News

Handbook increases ability to write pain prescriptions

The OSMA's handbook on chronic intractable pain appears to be doing its job, as the first questionnaires from *Pain - The Fifth Vital Sign* are received.

Background

Pain - The Fifth Vital Sign is a multipurpose tool distributed by the OSMA to all Ohio physicians in January 1999. This handbook provides some of the latest information on pain management and provides two hours of CME credit for those who complete the questionnaire/evaluation. The OSMA Ad Hoc Committee on Pain Education developed the handbook as part of an agreement struck with the state Legislature, which originally wanted to mandate two hours of CME for all Ohio physicians, regardless of whether such training would be useful to their practices. Now, as more than 1,000 questionnaires have been received by the OSMA, the resulting data potentially will be used as statistics when pain-oriented legislation is introduced and moves through the Ohio General Assembly.

Results

Early results from the questionnaire

show that approximately half of all readers achieved the highest level of understanding related to six issues: legal and regulatory requirements related to opioid treatments; taking appropriate medical histories; understanding the full range of potential treatments; differentiating potential treatments; current thinking on preventing chronic nonmalignant pain; and discriminating among tolerance, addiction and dependence.

After completing the pain handbook, several issues were rated strongly. They include increased levels of current knowledge related to pain management, and its clinical manifestation. Two-thirds of the respondents indicated that they now have an increased comfort level related to the legal and regulatory information in the handbook and will likely re-assess their patients' pain.

More than half the respondents plan to utilize all of the following resources that were part of the handbook: Intractable Pain Prescription Drug Checklist; Prescription Pain Medication Agreement; Pain Assessment Rules; and the CME Opportunities Listing.

Having read the handbook, nearly

80% of the respondents, in two almost exactly equal groups, said they now feel they have either increased ability to prescribe opioids or that the new pain rules pursuant to HB 187 will make no difference to their prescriptive patterns.

Pain management has been the topic of an increasing number of CME opportunities sponsored by the OSMA around Ohio. In 1998, more than 50 educational activities were scheduled. In 1999, close to three dozen opportunities for further training and CME credits are already on the calendar.

The OSMA is still accepting completed questionnaires. The OSMA can also send out additional copies of the pain handbook as requested. For OSMA members there is no charge; nonmembers are assessed a small charge, although everyone's original copy was sent free of charge. CME credit can be earned throughout 1999.

- Yvonne H. Burry

Take Action

For further information about the handbook or on the educational seminars on this topic, contact the OSMA Educational Services office at (800) 766-6762.



CME opportunities

12th Annual Pediatric Summerfest

This CME program is among many courses offered by the more than 70 sponsors of CME accredited by the OSMA.

When: July 31 - Aug. 1

Sponsor: The Children's Medical Center, Dayton

Course Director: Sherman J. Alter, MD, director, Infectious Disease and Medical Education, The Children's Medical Center, Dayton; associate professor of Pediatrics, Wright State University School of Medicine

Speakers: Ten physicians who have expertise in various aspects of pediatric surgical issues in a primary care setting.

Objective: To recognize degrees of burn severity and develop treatment strategies; list indications for tympanostomy tubes; assess children for scoliosis; recall radiographic and clinical approach to abdominal pain in children; assess common eye disorders in pediatric patients; effectively manage children with vesicoureteral reflux; review laboratory safety assessment of blood and blood products; and review laparoscopic and other new approaches to common childhood surgical conditions.

Time: 7:30 a.m. - 12:30 p.m. each day at the Cincinnati Marriott Northeast, 9664 Mason-Montgomery Road, Cincinnati, OH 45040; telephone (513) 459-9800 or (800) 329-0364 (special room rates are available).

For further information contact: Cheri Russell, (937) 463-5128

Cost: \$175

CME credits: 8.5

New directory features group practice profiles

The OSMA's 1999 Group Practice Directory will provide you with information on how Ohio groups structure their practice, what they're paying physicians, and what benefits they offer.

Are you interested in seeing how your

group practice (three or more physicians for the purpose of the directory) compares to other groups around the state? Then you'll want the latest copy of the OSMA's *Group Practice Directory*.

The 1999 edition includes information about 247 groups, the highest number of respondents yet to OSMA's

group practice survey. The 1999 survey was mailed earlier this year by the Group Practice Advisory Section.

"The first edition of *Group Practice Directory* came out in 1994," says Susan Rupli, director of OSMA Group Practice Services. That directory featured infor-

Continued on page 12

New directory

Continued from page 11

BECAUSE THIS IS NO PLACE
FOR A DOCTOR TO OPERATE.

mation from 38 group practices. A second edition was produced in 1996, with 50 group practices highlighted. The survey response rate from group practices in 1997 was considered too minimal to justify publishing a directory in 1998.

"This year, we researched market trends, revised the survey, and reduced the number of survey pages from 10 (the first survey) to two," says Rupli. The survey was mailed to 900 group practices.

Information contained in each listing in the directory should be of interest to group physicians and administrators who are trying to decide:

- What benefits to offer;
- How to structure physician compensation;
- What providers to employ or contract with;
- Whether or not to offer in-office laboratory and pharmacy services.

The directory also provides a statistical chart that shows how most group practices are structured legally, and what benefits are typically provided to physician members. Another highlight: A list of the top 10 MCOs or insurance companies that account for the greatest revenue in group practices.

The directory is divided by county, so practices can be located easily.

"The survey also included information that allows us to track group practice business trends (i.e. mergers and acquisitions), organizational affiliations, and what OSMA services and benefits are used by group administrators and physicians," says Rupli.

All of this information will help the OSMA plan and develop programs and services that will help improve the benefits already offered OSMA group practice members. ■

Take Action

Group practices that responded to the OSMA group practice survey will receive a copy of the *Group Practice Directory free*. If your group did not respond to the survey, but you would like a copy, contact Susan Rupli, OSMA Group Practice Services, (800) 766-6762, Ext. 6775. You may also e-mail her at: groups@osmo.org or fax her at: (800) 766-6763. Cost to members is \$25; cost to nonmembers is \$50.

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RATING THE MALPRACTICE CARRIERS

July 1999

Are insurers prepared for Y2K?

In late March, Weiss Ratings, Inc., released the results of its latest survey and evaluation of the Y2K preparedness of U.S. insurance companies and HMOs.

Of 5,453 companies receiving the survey, fewer than one in five – 984 (18%) – responded. Of those that responded, 253 (25.7%) have “made inadequate progress,” according to Weiss.

Responding Companies’ Y2K Preparedness Progress:

82 (8.3%)	High
649 (66.0%)	Average*
118 (12.0%)	Below Average
135 (13.7%)	Low
984 (100%)	Total Respondents**

* Average indicates adequate preparations at the time of the Weiss news release (March 29, 1999)

** of 5,453 companies and HMOs receiving surveys

“To find one-quarter of the respondents behind schedule is very disconcerting,” says Martin D. Weiss, PhD, chair of Weiss Ratings, Inc. “However, I’m even more concerned about the group that did not respond to the survey. It is reasonable to expect that an even greater percentage of these nonrespondents are behind schedule, given the tendency for better-prepared companies

to come forward more readily.”

Among the largest companies with “high” Y2K ratings was Ohio-based Nationwide Life & Annuity Insurance Co., with total assets of \$1,958.2 million.

The Y2K survey, mailed on Dec. 30, 1998, asked 13 questions about each company’s time line for completing various milestones in the Y2K remediation and testing process. Weiss then evaluated the actual or expected completion dates for critical tasks, using, as a reference point, standards established in September 1998 by the National Association of Insurance Commissioners (NAIC).

Weiss advised consumers and analysts to judge the Y2K ratings in the context of a company’s overall financial strength. “An insurer with abundant capital resources is better equipped to remedy its Y2K problems today and cope with any consequences after the year 2000. In contrast, an insurer with apparent deficiencies in both its Y2K progress and its financial stability may be at serious risk.

“Based on some of the expected Y2K completion dates we’ve seen, it appears that many insurance companies are not even aware of regulators’ time lines for fixing and testing their computer systems,” Weiss said. “At the very minimum, the insurance commissioners should collect –

and disclose to the public – current data on the status of each insurer registered in their state.

“Unlike the banking industry, where federal regulators have mounted an aggressive national Y2K effort, the insurance industry is regulated by individual state departments, each of which is giving varying degrees of attention to the Y2K problem.”

According to Weiss, both consumers and regulators have expressed growing concerns that ill-prepared insurance companies may be unable to properly process claims, track customer accounts, and disburse annuity payments after Jan. 1, 2000.

Weiss will be mailing one more Y2K preparedness survey to U.S. insurance companies and HMOs before the end of this year. Results are expected to be available by October.

Weiss Y2K and Safety ratings on financial institutions are available for a modest fee directly from Weiss (800) 289-9222. If a Y2K Rating is not available, callers will receive a Weiss Safety Rating, plus specific information on how to contact the Year 2000 project manager or financial officer at their insurance company. –

Carol Larimer

Selected insurance companies that write medical malpractice insurance coverage in Ohio	NAIC Code	A.M. Best Rating	A.M. Best Dates	S&P Rating	Weiss Rating
American Continental Ins. Co.*	12246	A g	4/21/99	Api	C
American International Insurance Co. **	32220	A++ g	8/20/98	AAA	B-
Chicago Insurance Co. *	22810	A+ p	1/25/99	Api	B-
Cincinnati Insurance Co. (The)*	10677	A++ g	5/18/98	AA+	B
Continental Casualty Co., * member of CNA Insurance **	20443	A p	9/29/97	A+	C+
Doctors' Co., an Inter- insurance Exchange (The) * ***	34495	A g	4/26/99	BBBpi	A-
Evanston Insurance Co. **	35378	A g	1/25/99	A+	C-
Frontier Insurance Co. * ***	34266	A- g	12/28/98	A+	C+
Gulf Insurance Co. *	22217	A+ p	6/8/98	AA	B
Health Care Indemnity Inc. *	35904	A-	4/26/99	BB+pi	not rated
Kentucky Medical Ins. Co. * ***	38105	A- r	8/31/98	A+	B
Medical Protective Co. * ***	11843	A	4/26/99	AA	B-
Medical Inter-Insurance Exchange of NJ * ***	34398	A	2/23/98	BBBpi	B-
Mutual Assurance Inc. * ***	33391	A g	5/24/99	A+	B
National Union Fire Insur- ance Co. of Pittsburgh, PA **	19445	A++ g	8/20/98	AAA	B+
OHIC Insurance Co. * ***	35602	A-	1/25/99	A	C+
PHICO Insurance Co. * ***	35718	A- g	11/23/98	NR	C
Professionals Advocate Ins. Co.** (S&P: Mid-Atlantic Medical Ins. Co.)	29017	A-	4/26/99	BBBpi	C+
ProNational Insurance Co. ** (a merger of PICOM Insurance Co. & PPTF, effective 7/98)	38954	A- g	3/16/98	A-	C

CURRENT GUIDE TO BEST'S RATINGS

March 30, 1998

For a complete explanation of Best's Ratings, please refer to the Preface of *Best's Insurance Reports*[®] or *Best's Key Rating Guide*[®]. Best's Ratings reflect our independent opinion, but are not a warranty of a company's financial strength and ability to meet its obligations to policyholders.

BEST'S RATINGS AND FINANCIAL PERFORMANCE RATINGS (FPR)

A.M. Best assigns to insurance companies one of two types of rating opinions, a Best's Rating (A++ to F) or a Financial Performance Rating (9 to 1). The Best's Rating represents an opinion based on a comprehensive quantitative and qualitative evaluation of a company's financial strength, operating performance and market profile. The FPR represents an opinion based primarily on a quantitative evaluation of a company's financial strength and operating performance. Best's Ratings and FPRs provide an independent opinion of an insurance company's ability to meet its obligations to policyholders. For additional information, refer to the Preface.

Secure Best's Ratings		
A++ and A+	.....	Superior
A and A-	.....	Excellent
B++ and B+	.....	Very Good

Secure FPR Ratings		
FPR 9	.....	Very Strong
FPR 8 and 7	.....	Strong
FPR 6 and 5	.....	Good

Vulnerable Best's Ratings		
B and B-	.....	Fair
C++ and C+	.....	Marginal
C and C-	.....	Weak
D	.....	Poor
E	.....	Under Regulatory Supervision
F	.....	In Liquidation
S	.....	Rating Suspended

Vulnerable FPR Ratings		
FPR 4	.....	Fair
FPR 3	.....	Marginal
FPR 2	.....	Weak
FPR 1	.....	Poor

RATING MODIFIERS

Rating Modifiers are assigned to Best's Ratings and Financial Performance Ratings to identify companies whose rating opinions are Under Review (u) and may be subject to near-term change, or are based on a Group (g), Pooling (p) or Reinsurance (r) affiliation with other insurers. For additional information, refer to the Preface.

g - Group
p - Pooled

r - Reinsured
u - Under Review

NOT RATED CATEGORIES (NR)

Companies not assigned a Best's Rating or FPR are assigned to one of five NR categories which identifies the primary reason a rating opinion was not assigned to the company. For additional information, refer to the Preface.

NR-1	.....	Insufficient Data	NR-4	.....	Company Request
NR-2	.....	Insufficient Size and/or Operating Experience	NR-5	.....	Not Formally Followed
NR-3	.....	Rating Procedure Inapplicable			

FINANCIAL SIZE CATEGORIES (FSC)

Assigned to all companies and reflects their size based on their capital, surplus and conditional reserve funds in millions of U.S. dollars, using the scale below. For additional information, refer to the Preface.

FSC I	less than 1	FSC V	10 to 25	FSC IX	250 to 500	FSC XIII	1,250 to 1,500
FSC II	1 to 2	FSC VI	25 to 50	FSC X	500 to 750	FSC XIV	1,500 to 2,000
FSC III	2 to 5	FSC VII	50 to 100	FSC XI	750 to 1,000	FSC XV	greater than 2,000
FSC IV	5 to 10	FSC VIII	100 to 250	FSC XII	1,000 to 1,250		

How to obtain the latest Best's Ratings

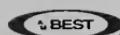
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The Insurance Information Source

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Standard & Poor's Insurer Financial Strength Ratings Definitions

A Standard & Poor's Insurer Financial Strength Rating is a current opinion of the financial security characteristics of an insurance organization with respect to its ability to pay under its insurance policies and contracts in accordance with their terms. This opinion is not specific to any particular policy or contract, nor does it address the suitability of a particular policy or contract for a specific purpose or purchaser. Furthermore, the opinion does not take into account deductibles, surrender or cancellation penalties, timeliness of payment, nor the likelihood of the use of a defense such as fraud to deny claims. For organizations with cross-border or multinational operations, including those conducted by subsidiaries or branch offices, the ratings do not take into account potential that may exist for foreign exchange restrictions to prevent financial obligations from being met.

Insurer Financial Strength Ratings are based on information furnished by rated organizations or obtained by Standard & Poor's from other sources it considers reliable. Standard & Poor's does not perform an audit in connection with any rating and may on occasion rely on unaudited financial information. Ratings may be changed, suspended, or withdrawn as a result of changes in, or availability of such information or based on other circumstances.

Insurer Financial Strength Ratings do not refer to an organization's ability to meet nonpolicy (i.e. debt) obligations. Assignment of ratings to debt issued by insurers or to debt issues that are fully or partially supported by insurance policies, contracts, or guarantees is a separate process from the determination of Insurer Financial Strength Ratings, and follows procedures consistent with issuer credit rating definitions and practices. Insurer Financial Strength Ratings are not a recommendation to purchase or discontinue any policy or contract issued by an insurer or to buy, hold, or sell any security issued by an insurer. A rating is not a guaranty of an insurer's financial strength or security.

Insurer Financial Strength Ratings

An insurer rated 'BBB' or higher is regarded as having financial security characteristics that outweigh any vulnerabilities, and is highly likely to have the ability to meet financial commitments.

AAA

An insurer rated 'AAA' has EXTREMELY STRONG financial security characteristics. 'AAA' is the highest Insurer Financial Strength Rating assigned by Standard & Poor's.

AA

An insurer rated 'AA' has VERY STRONG financial security characteristics, differing only slightly from those rated higher.

A

An insurer rated 'A' has STRONG financial security characteristics, but is somewhat more likely to be affected by adverse business conditions than are insurers with higher ratings.

BBB

An insurer rated 'BBB' has GOOD financial security characteristics, but is more likely to be affected by adverse business conditions than are higher rated insurers.

An insurer rated 'BB' or lower is regarded as having vulnerable characteristics that may outweigh its strengths. 'BB' indicates the least degree of vulnerability within the range; 'CC' the highest.

BB

An insurer rated 'BB' has MARGINAL financial security characteristics. Positive attributes exist, but adverse business conditions could lead to insufficient ability to meet financial commitments.

B

An insurer rated 'B' has WEAK financial security characteristics. Adverse business conditions will likely impair its ability to meet financial commitments.

CCC

An insurer rated 'CCC' has VERY WEAK financial security characteristics, and is dependent on favorable business conditions to meet financial commitments.

CC

An insurer rated 'CC' has EXTREMELY WEAK financial security characteristics and is likely not to meet some of its financial commitments.

R

An insurer rated 'R' has experienced a REGULATORY ACTION regarding solvency. The rating does not apply to insurers subject only to nonfinancial actions such as market conduct violations.

NR

An insurer designated 'NR' is NOT RATED, which implies no opinion about the insurer's financial security.

Plus (+) or minus (-) signs following ratings from 'AA' to 'CCC' show relative standing within the major rating categories.

CreditWatch highlights the potential direction of a rating, focusing on identifiable events and short-term trends that cause ratings to be placed under special surveillance by Standard & Poor's. The events may include mergers, recapitalizations, voter referenda, regulatory actions, or anticipated operating developments. Ratings appear on CreditWatch when such an event or a deviation from an expected trend occurs and additional information is needed to evaluate the rating. A listing, however, does not mean a rating change is inevitable, and whenever possible, a range of alternative ratings will be shown. CreditWatch is not intended to include all ratings under review, and rating changes may occur without the ratings having first appeared on CreditWatch. The "positive" designation means that a rating may be raised; "negative" means that a rating may be lowered; "developing" means that a rating may be raised, lowered or affirmed.

'pi' Ratings, denoted with a 'pi' subscript, are Insurer Financial Strength Ratings based on an analysis of published financial information and additional information in the public domain. They do not reflect in-depth meetings with an insurer's management nor do they incorporate material non-public information, and are therefore based on less comprehensive information than ratings without a 'pi' subscript. 'pi' ratings are reviewed annually based on a new year's financial statements, but may be reviewed on an interim basis if a major event that may affect an insurer's financial security occurs. 'pi' ratings are not modified with '+' or '-' designations, nor are they subject to potential CreditWatch listings.

National Scale Ratings, denoted with a prefix such as 'mx' (Mexico) or 'ra' (Argentina), assess an insurer's financial security relative to other insurers in its home market. For more information, refer to the separate definitions for national scale ratings.

Quantitative Ratings, denoted with a 'q' subscript, were discontinued in 1997. The ratings were based solely on quantitative analysis of publicly available financial data.

President's Perspectives

Managed-care reform: Step two

Since a second legislative victory for the OSMA – well – almost. Substitute House Bill 4, Gov. Bob Taft's Patient Protection plan, passed the Ohio House last month and is now in the Senate. This bill promises to be as beneficial for our patients as the Physician-Health Plan Partnership Act (PHPPA), which became law last year.



Dr. Ullok

Introduced by Rep. Randy Gardner (R-Bowling Green) at the beginning of this legislative session, Sub. HB 4 has been supported by the OSMA from the outset because of its meaningful patient protections. One of the bill's most significant provisions, for example, provides for an external review of disputes that arise between patients and HMOs.

This is no small accomplishment. Let me explain what this means for our patients: First, the external review process will be **independent**. Sub. HB 4 stipulates that the external review organization can not be affiliated financially with the HMO – and the HMO may *not* select the medical expert who will serve as reviewer. Second, the review will be **objective**. That's because HB 4 says that the medical expert must be a "clinical peer," practicing in the same specialty as the treating physician. In addition, this expert must use an "evidenced-based decision-making process," consulting findings and research from government and nationally-recognized organizations, as well as peer-reviewed medical and scientific literature. And third, the review will be **meaningful** because the HMO – not the patient – must bear the full cost of the external review process. Further, if the independent medical expert deems a procedure is medically necessary, the HMO will be required to provide the coverage.

In the current legislation, there is no
continued on page 16

OSMA Insurance Agency

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On the Web...

Contact your legislator

Now you can locate your legislator and communicate with him or her via electronic mail. A new program in the Legislation section of the OSMA Web site (www.osma.org) called "Find Your Legislator" not only gives you the name, address, phone number, Web site and e-mail addresses of your representative, but also tells you what bills are being tracked by the OSMA and legislative alerts and updates.

This new feature helps members find their legislative representative by simply typing in their ZIP code.

After you type in your ZIP code the name(s) of your representatives will appear. When you click on the particular individual's name a photo of the representative will appear along with personal background information and political service.

This new service also gives you tips on writing to your state legislator, for instance, be specific, state your position, ask for a response and follow up—if you agree with your legislator's vote, take the time to let him/her know that. Similarly, if you disagree with his/her vote, inform your legislator.

Other features of this new service allows members to:

- Browse the legislative directory.
- Locate important issues the OSMA is tracking for you.
- Get the latest legislative news, session dates and U.S. Congress news.
- Join the OSMA's grassroots e-mail action team. (When you sign up for the mailing list you will be notified when you can make a critical difference on important issues.)

While visiting the Legislative section of the OSMA Web site, members can go to "Current Bills" to find out the status of a bill and the OSMA position, or complete a PLAN or OMPAC application if you aren't already a member. ■

Take Action

Comments and suggestions about the OSMA Web site are welcomed. Please e-mail Karen Kirk at kirk@osmo.org or call her at (800) 766-6762, Ext. 6754.

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Is it good medicine?

The following information comes from the report that AMA Board of Trustee member, Herman I. Abramowitz, MD, Dayton, presented to the OSMA House of Delegates in Moy.

By Herman I. Abramowitz, MD

You can be assured that the AMA is fervently advocating for our patients and physicians on numerous issues every day throughout the year. And I appreciate this opportunity to share with you some of the very important activities which have engaged our energies this past year.

One year ago at this time, the subject of E&M guidelines was being furiously debated. That subject continues to challenge us, and, in the end, we will hold that process to the highest standard by asking: Is this good medicine?

Much effort has been invested in the AMA's Private Sector Advocacy program. Our aim is to give physicians practical, hands-on help in fighting unfair practices and managed-care contracts that are flagrantly abusive of physicians and their patients.

The AMA challenged the proposed merger of Aetna/U.S. Healthcare and Prudential, which has the potential for creating a health-care entity which could cover one in 10 American lives. As all aspects of that, or any such merger are viewed, the question must be answered: Is this good medicine?

And our attentions are also focused this year on the subject of medical fraud and abuse, particularly as the Department of Justice targeted this as "the crisis of the '90s" and the Health Care Financing Administration (HCFA) enjoined the American Association of Retired Persons (AARP) and offered "rewards" to Medicare beneficiaries if they called to report any questionable billing practices by their physician. From our view, the focus of this type of activity serves only to drive a wedge in the trust relationship between doctor and patient when the perception is assumed that physicians and other health-care professionals are inherently dishonest perpetrators of fraud. Again,



Herman I. Abramowitz, MD, Dayton, presented his AMA report to the OSMA House in Moy.

we must ask: Is this good medicine?

In addition to fraud and abuse, the AMA has identified seven other public sector advocacy initiatives for 1999. These include:

- 1.) Managed-care reforms.
- 2.) Antitrust relief. The Campbell bill (in the U.S. Congress) has just been reintroduced, and would empower individual, self-employed physicians to engage in joint negotiations with health plans.
- 3.) Health insurance reforms. We will seek changes in federal tax code policy that will facilitate a transition from an employer-based to an individually-owned insurance system.
- 4.) Regulatory relief, including HCFA, Clinical Laboratory Improvement Amendments (CLIA), and many others.
- 5.) Medicare reforms. We must ensure the long-term solvency of the Medicare program.
- 6.) Funding to support clinical research.
- 7.) Public Health initiatives, which include passage of legislation establishing FDA authority to regulate tobacco, as well as other evolving public health priorities.

These eight initiatives (including fraud and abuse) do not encompass an entire agenda, however, the AMA is also committed to professional liability reform, protecting the privacy of medical records and confidentiality, and blocking assisted-suicide legislation which could have a chilling effect on appropriate pain management services.

Our focus is clear. No matter what health-care policy or action is contemplated,

continued on page 16

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September 17, 1999

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world renowned sleep specialists:

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Mary Caerskhan, Ph.D.

Michael Thorpy, M.D.

Robert Hinkle, DDS

Helmut S. Schmidt, M.D.

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Treatment options for Sleep Apnea

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KEYNOTE
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Federation of Medicine

From the county files...

Mahoning County polishes physician image

The Mahoning County Medical Society (MCMS) has implemented its Community Outreach Project 1999 to increase visibility, understanding, and value in the northeast Ohio area while also potentially attracting new members.

MCMS President Thomas N. Detesco, MD, says, "We are engaging several targeted audience groups through a series of communications vehicles." The intended audiences include labor unions, senior citizens, the media, employers who select health-care programs for their employees, and legislators.

Six different communication vehicles are part of the Outreach effort: dinners with targeted groups, advertisements, radio and TV talk show appearances, news releases, editorial contact,

and a membership campaign. Through these mechanisms, the MCMS wants the targeted general public sectors to come away with a greater understanding that physicians' primary concern is the health and well-being of their patients, that physicians are the best qualified persons to decide on what is appropriate health care, and that top-quality health care is available in Mahoning County. Another important message to the audiences will be that the MCMS is the community's best source for health-care information.

Says Dr. Detesco, "The Outreach Project is unique in its ongoing nature of contact with many public sectors. With the rapidly evolving political, social and economic changes occurring in society, the physician's role as

teacher and leader is taking on greater responsibility." By scheduling a multiplicity of community events, local physicians will have increased contact with key community leaders in a professional setting that supports an active exchange of information and support.

Part of the current Outreach schedule includes a series of four dinners with MCMS President Dr. Detesco, community leaders and the MCMS physician committee. These four dinners will target labor union leaders, senior citizens, local employers and local legislators, in that order. The first scheduled dinner took place June 10.

Outreach for members and prospective members of MCMS has also increased. In April, MCMS inaugurated their "MCMS FACTS" publication — a

monthly, two-page newsletter distributed by fax to members and nonmembers. The society also publishes *The Bulletin of the Mahoning County Medical Society* quarterly. — Yvonne H. Burry

Toke Action

"From the county files..." is designed to show how county medical societies are identifying and responding to issues in their area with programs and activities that you may wish to borrow for your county. If you would like more information about this particular program, contact Eleanor Persing, executive director, at (330) 758-1624.

Managed-care

continued from page 13

requirement that HMOs use "ordinary care" when making utilization review decisions. However, we believe that such statutory language is not really necessary because common law has developed to the point where courts today are holding HMOs liable for failing to exercise ordinary care if it's proven that they have failed to do so.

In all respects, then, we are satisfied with this bill. Coupled with the patient protections enacted under the PHPPA, Sub. House Bill 4 promises to be another giant step forward in our efforts to achieve significant reform in the managed-care arena.

We hope this will be our second legislative victory in as many years. Certainly, our patients need this bill. But we need your support to turn it into a reality. Write your senators — now — and let them know how important this bill is to Ohio's patients — our patients.

We can manage managed care if we work together. We can make a difference. And our patients will be better off for our efforts. Join us in supporting Sub. House Bill 4. ■

Toke Action

If you need to know the name and/or address of your senator, you can find it by visiting the OSMA Web site, www.osmo.org, go to the "Legislation Section."

Is it good

continued from page 15
plated, it must meet the critical demand: Is this good medicine?

As you can tell, our AMA is very busy working with you and for you — and any successes we can enjoy are contingent upon us working together.

We need strong participation of grassroots physicians around the country. Working together, we can pool resources and bring substantial forces to bear to ensure that the integrity of the physician-patient relationship remains paramount.

None of us is as strong as all of us together. That's what organized medicine is all about. And together we are bringing our strength to bear for the patients and physicians of America. ■

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Practice Tips

Retirement planning

Considering long-term care insurance?

Ideally, in planning your retirement, you will have explored the standard of care that is acceptable to you. By the time you are age 60 you should know whether or not long-term care insurance is for you.

Jim Budros, CFP, of Budros & Ruhlin, explained the process as two-fold: "First, you determine need from the analytical front; then you approach the decision from the psychological or emotional side."

"Financial planners will gather the facts and personal objectives, then examine alternatives. For instance, the average long-term stay in a Columbus nursing home is less than two years. In the event of disability, for some physician-consumers, the cost of daily long-term care may be less than their normal cost of daily living. In that scenario, the financial risk of covering the cost of care is not very high."

According to American Health Care Association statistics, the cost of private nursing home care averages \$125/day, depending on services required and geographic location. About 11% of nursing home patients are younger than 65 years. And the trend is toward shorter-term stays for people with stable, but chronic conditions.

Of course, many types of facilities and home health-care options are available for different levels of care, and at varying costs. Health-care institutions provide only 22% of long-term care. The balance is provided at home or in the community.

What's covered, for how long?

Definitions for these options vary across policies and states. Guidebooks suggest that after deciding on the types of facilities you prefer, to cross-reference what's available in your area. Also, before entering a particular type of facility, check with your insurance

agent to make sure that type is covered by your policy. Even physician-consumers usually don't know how long their own special care will be required, however, and reducing personal assets against an unknown future can be scary.

"A common objective, as people get older, is independence from their children," says Budros. "Preservation of an estate for future generations is a common goal that can be better assured by shifting risk to a long-term care insurance 'partner.'

From a financial standpoint, Budros continues, the cost of long-term care is tax-deductible since it's a substitute for hospital care. If you're in a 30% tax bracket — spending the same amount on long-term care that you would have on normal living expenses actually gives you a 30% advantage. "And you realize a double-benefit when withdrawing from a retirement plan, which is untaxed income and therefore also worth one-third more."

Emotional aspects to consider

For many people with adequate assets, being the "victim" of improbable circumstances is not an insurable risk when you realize that the insurance company must make a profit and your cost of care will likely be less than your normal cost of living. However, the decision is usually more complicated than that. Making a decision will invariably have an emotional aspect that will vary with many factors. For instance, a consumer might have just finished a 10-year ordeal with an elderly parent who insisted on staying at home and was not covered by long-term care insurance. In this case, the surviving (adult) child might view a long-term care future without insurance coverage as one that leads to exhausted resources, dependence, and frustrated relationships.

"If a person with that experience is reluctant to make significant gifts to

their children, that would eventually realize large estate-tax savings, the assurance gained from less-expensive, long-term care insurance could be the helpful tool that frees them to move in an analytic direction," says Budros.

He continues: "While people may need long-term care before retirement, planning for retirement is one of the trigger events for thinking about it. So, ideally, no later than age 60, we need to explore the standard of care that is acceptable to the individual. Long-term care insurance premiums are much lower when purchased at an earlier age. And generally, in insurance, the level of premium equals the level of benefits. Most people would prefer to remain in their own homes for short-term or long-term care, with specialized care coming to them."

Some long-term care benefits are paid by the "expense incurred" method. Once you have been determined as eligible for benefits and submit your claims, the insurance company pays you or the provider up to the limits contained in the policy. Under the "indemnity" type of benefits, once you have been determined as eligible, the insurance company will pay benefits directly to you in the amount specified in the policy, without regard to the specific services received. This type of policy makes it possible to receive care from noncertified caregivers such as family members or friends, and also receive your insurance benefits.

"People also need to understand the sufficiency of their accumulated estates and be willing to think differently about them. For instance, in retirement, you don't need income; you need cash, and systematic withdrawal of principal can be a good thing. However, not all people are comfortable with diminishing principal in retirement because of future uncertainties. For those people, long-term care insurance is a reassuring, practical tool." — *Carol Larimer*

OSMA's contract review service

Benefits of OSMA membership include a free contract review service. The Legal Services Department averages 15 review requests a month.

The review, revised earlier this year, consists of three sections:

- comments about provisions in a specific contract that may be unique or especially onerous or that may need amplification;

- basic issues and provisions the OSMA recommends physicians look for in any managed-care contract; and

- provisions Ohio law requires in every provider contract issued by a health insuring corporation (HIC).

The review does not make recommendations on whether a physician should sign on with a particular HIC. Rather, it is intended to provide enough contract information for the physician to make an informed decision on participating. "Hopefully, from using the analysis they can determine on their own, based on what they know about their practice, whether or not it's a good one for them to participate in," says Kate Hunter, OSMA Division of Legal Affairs. Hunter adds two or three contract analyses to the files each month. As she receives new contracts or updates old ones, she reviews them according to the new format. In reading a new contract, she marks items that stand out to her. "I just try to note anything that looks unusual, maybe something I've never seen before. It's not only bad things. If I see something good, I try to point that out also. For example, I got one recently that says that the physicians can be paid for records that they provide. Generally the contract says you agree to provide copies of medical records at no expense."

Hunter suggests guidelines when requesting a review:

- Call first. The OSMA has about 120 analyses on file, so there may already be a review available.
- If the contract you're asking about isn't on file, send a copy, not the original.
- Expect to receive the contract analysis in about eight weeks. — *Jan Leibovitz Alloy*

Take Action

For more information, contact Kate E. Hunter, OSMA Division of Legal Affairs, (800) 766-6762, Ext. 6766.

Your Practice Guide

Checklist for improving your Medicaid reimbursements

If you find that Medicaid pays your claims slowly, or not at all, following these tips may help.

Report practice changes.

If changes have occurred in your practice, it's important to notify the Medicaid department as soon as possible. Failure to do so may result in nonpayment situations or payment delays. Notify the department within 30 days in writing when changes/updates occur in your address, federal tax identification number, telephone number, name, ownership, and Medicare provider number assignment.

Notify Medicaid in writing of assigned Medicare provider number. It's important to notify Medicaid, in writing, of your assigned Medicare provider number(s). This can be done by submitting written notification to Medicaid's Provider Enrollment Unit at P.O. Box 1461, Columbus, OH 43266-0161. Your Medicare provider number must be on file with the department to facilitate the automatic Medicare/Medicaid claims crossover process. This applies to most provider types, including practitioners and group practices. Please contact our Provider Enrollment Unit to establish or verify the association of your

Medicaid and Medicare provider numbers in our system. The provider number association will promote the automatic Medicare/Medicaid claims crossover process for your practice. Without it, your automatic Medicare/Medicaid crossover payment will not occur. Please contact the Provider Enrollment Unit at (800) 686-6108, option 2, for additional information.

Place Medicaid provider number in proper location. Improper placement of your Medicaid provider number on claims submitted to the department will affect your Medicaid payments. The positioning of your seven-digit Medicaid provider number is a critical data element on the claim form for proper payment and creating an audit trail. Claims submitted to Medicaid with missing provider numbers, misplaced provider numbers, non-Medicaid provider numbers, such as Medicare provider numbers or federal tax IDs, or truncated seven-digit provider numbers are deleted from our processing system, leaving no audit trail. This explains why the department would have no record of your previously submitted claims. Please refer to the specific claim type billing instructions for proper placement of your seven-digit Ohio Medicaid provider number.

The provider number placement problem appears to be most prevalent in Item 33 of the HCFA 1500 invoices submitted to the department. For Item 33, enter the provider number(s) as follows:

- PIN # – Enter the Medicaid provider number assigned to the provider billing for the service in the space directly to the right of "PIN #." When the billing provider is a group practice, the provider number assigned to the individual who performed the service must go in this space, and the provider number assigned to the group practice must be entered in the space directly to the right of "GRP#."

- GRP # – The space directly to the right of "GRP#" must be left blank, unless billing for a group practice. A provider number assigned to an individual practitioner, clinic, DME dealer, Ambulatory Surgery Center, etc., should never be entered in this space. (See PIN # instructions.)

- Submit unpaid Medicare cross-over claims directly to Medicaid. As you may recall, the department experienced automatic Medicare/Medicaid crossover problems during the months of August through December 1998. During that time, remittance advice notices were generated by Medicaid to keep you informed. Medicaid's last update for Part B issues was on the Dec. 9, 1998 remittance advice, and for Part A issues the Feb. 3, 1999 remittance advice. To date, those issues which affected both Parts A and B automatic crossover processing appear to be resolved. For those services that you billed to Medicare during the August through December 1998 period – and you have yet to receive an automatic crossover payment – please submit those claims directly to us. The department requests that you submit these claims in lieu of hard copy submission. Per Medicare/Medicaid Crossover Billing Instructions, when the automatic Medicaid reimbursement of co-insurance and deductible has not been made within 60 to 90 days of the Medicare reimbursement, the provider is to bill Medicaid for the coinsurance and deductible. The provider may bill the Medicare/Medicaid crossover claims on tape following the National Standard Format. Contact Medicaid's Provider Enrollment Unit at: In-state, (800) 686-6108, option 2; or Out-of-state: (614) 728-3288. ■



Multiple diagnosis coding explained

OSMA's coding specialist Jillian Phillips answers coding questions that arise when a patient presents with multiple conditions, diseases or problems.

One of the more confusing issues about diagnosis coding concerns patients who present with multiple conditions/diseases/problems. When there are only four

diagnoses allowed on a claim form, two questions arise:

- What is the proper way to determine which codes to report?
- In what order are they reported?

While there are some specific rules regarding coding for multiple diagnoses in the various categories, one rule of thumb remains: Code the reason for the encounter first as the primary diagnosis. If there are other conditions/diseases/problems present

which are also the reason for the encounter, or which directly affect management and care, then those should be sequenced and reported in the order of severity after the primary code.

The following additional information may be used in the defined situations as guidelines for reporting other (additional) diagnoses, and are just a small part of the official guidelines for coding and reporting

ICD-9-CM:

General rule

For reporting purposes, the definition for "other diagnoses" is interpreted as additional conditions that affect patient care in terms of requiring:

- clinical evaluation; or
- therapeutic treatment; or
- diagnostic procedures; or
- extended length of hospital stay; or
- increased nursing care and/or

Continued on next page

Your Practice Guide

Multiple diagnosis...

Continued from page 18

monitoring.

The following guidelines are to be applied in designating "other diagnoses" when neither the Alphabetic Index nor the Tabular Listing ICD-9-CM of the St. Anthony's version of ICD-9-CM provide direction.

The listing of the diagnoses on the attestation statement is the responsibility of the attending physician.

Previous conditions

If the physician has included a diagnosis in the final diagnostic statement, such as the discharge summary or the face sheet, it should ordinarily be coded. Some physicians include in the diagnostic statement resolved conditions or diagnoses and status-post procedures from previous admission that have no bearing in the current stay. Such conditions are not to be reported and are coded only if required by hospital policy. However, history codes (V10-V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

Diagnoses not listed in the final diagnostic statement

When the physician has documented what appears to be a current diagnosis in the body of the record, but has not included the diagnosis in the final diagnostic statement, the physician should be asked whether the diagnosis should be added.

Conditions that are an integral part of the disease process

Conditions that are integral to the disease process should not be assigned as additional codes.

Conditions that are not an integral part of a disease process

Additional conditions that may not be associated routinely with a disease process should be coded when present.



Abnormal findings

Abnormal findings (laboratory, X-ray, pathologic, and other diagnostic results) are not coded and reported unless the physician indicates their clinical significance. If the findings are outside the normal range and the physician has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the physician whether the diagnosis should be added.

St. Anthony's International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is the best reference for the most accurate reporting of diagnosis codes. All of the other coding references contain many mistakes, and lack sufficient instructions for the accepted "official" coding guidelines. —
Jillian Phillips, MA, CPC, CCS-P.

Take Action

In the first half of the year 2000, Jillian Phillips, OSMA's coding specialist, will present a series of all-day workshops for CPT and ICD-9-CM coding, and St. Anthony's ICD-9-CM will be the preferred reference material of one of the day-long sessions. Any physician member and/or their staff may call Phillips with any specific questions regarding coding: (800) 766-6762, Ext. 6758. Questions may also be faxed to her attention at (614) 527-6763.

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Your Practice Guide

Chart Auditing: self-defense

You may be shortchanging yourself and your practice if you don't know how to audit your own charts. Seminars, offered this fall, will teach you what you need to know to protect yourself during E&M audits.

Doctors are being down coded in pre- and post-audits, and often they shouldn't be, according to Jillian Phillips, MA, CPC, CCS-P, OSMA's coding specialist. "We have handled many claims here in the Ombudsman Department which have resulted in third-party payors reversing their down coding decisions based on our audits."

That's why, this fall, due to popular demand, she is once again offering one-day "self-defense" courses for members and their staffs, to help them defend themselves during chart audits of their evaluation and management (E&M) services. "We teach the staff how to audit their own records so they know whether or not the auditor has been fair in dealing with them," says Phillips.

A second reason for auditing your own chart: If you code the wrong E&M service, you can cheat yourself out of money and risk audit sanctions.

During the morning portion of the seminar, Phillips will discuss the old, new and proposed E&M guidelines, and will help you and/or your staff determine which guidelines will best suit your needs. "In the afternoon, there will be an extensive hands-on session



in auditing multi-system and specialty records," says Phillips. Charts will include new patient visits, office/outpatient services, preventive medicine visits, consults and hospital visits. Discussions will also be held on the best way to interpret physicians' notes for selecting the correct level of E&M service. In addition, participants will learn how to audit a medical record in five minutes. "Time is valuable," says Phillips. "You shouldn't have to spend

more time than that auditing charts."

The seminars will be offered around the state during September and October as follows:

- Sept. 14 - Athens
- Sept. 16 - Zanesville
- Sept. 21 - Youngstown
- Sept. 22 - Cleveland
- Sept. 28 - Cuyahoga Falls
- Sept. 29 - Canton
- Oct. 5 - Cincinnati
- Oct. 6 - Dayton
- Oct. 13 - Mansfield
- Oct. 14 - Columbus
- Oct. 19 - Elyria
- Oct. 20 - Toledo

Space at these sessions will be limited, so if you or your staff are interested in attending, register promptly (see "Take Action"). Brochures about the seminars will mail soon.

"It's important to know how to audit your own chart, or you make yourself and your practice very vulnerable," says Phillips. "Knowledge is power." ■

Take Action

If you have questions or need more information about the content of the seminars, contact Jillian Phillips, OSMA Department of Ombudsman Services, (800) 766-6762, Ext. 6758. If you would like to register for the seminars, contact Cathy Sonnholter in the same department, (800) 766-6762, Ext. 6759.

Coding book not endorsed by OSMA

You may have received information by mail, recently, offering OSMA members the *Coding Answer Book* at a discount rate of \$50 off the regular price.

You should know this offer is made by United Communications Group of Rockville, Maryland, without the endorsement, authorization or cooperation of the Ohio State Medical Association. The OSMA has not reviewed the *Coding Answer Book* and can't make any recommendations as to its value to physicians' practices.

The *Coding Answer Book* and the discount offer, or any other publication marketed by the United Communications Group, should not be considered an endorsed member benefit of the OSMA.

Questions regarding claims coding can be addressed directly to the OSMA Department of Ombudsman Services, (800) 766-6762.

The OSMA regrets any confusion caused by this mailing. If you have questions regarding this offer or any other offers that suggest the involvement, cooperation or endorsement of the OSMA, please do not hesitate to contact the OSMA staff, at (800) 766-6762. ■

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Any interested physician may contact Lawrence R. England, Executive Director at (740) 695-3430, or send your resume to: The Upper Ohio Valley Individual Practice Association, Inc., P.O. Box 356, 107 Plaza Drive, Suite B2, St. Clairsville, OH 43950.

"Credit Watch" explained by ratings service

The July 1999 issue of "Rating the Malpractice Carriers" is bound into this issue. Along with the ratings this month is an interesting article that describes the Y2K readiness of professional liability companies.

In the ratings, you will note that Standard & Poor's has indicated one malpractice carrier is under a "Credit Watch." Because Standard & Poor's definition of "CreditWatch" is not included in the key, it is given here:

CreditWatch highlights the potential direction of a rating, focusing on identifiable events and short-term trends that cause ratings to be placed under special surveillance by Standard & Poor's. The events may include mergers, recapitalizations, voter deviation from an expected trend occurs and additional information is needed to evaluate the rating. A listing, however, does not mean a rating change is inevitable, and whenever possible, a range of alternative ratings will be

shown. CreditWatch is not intended to include all ratings under review, and rating changes may occur without the ratings having first appeared on CreditWatch. The "positive" designation means that a rating may be raised; "negative" means that a rating may be lowered; "developing" means that a rating may be raised, lowered or affirmed.

As always, it is wise to log onto the Web sites of the respective ratings services for more information and more up-to-date ratings on the companies they list. ■

Ohio Medicine

A Publication of the Ohio State Medical Association

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Ohio Medicine (ISSN 0892-2454/USPS 200-200) is published monthly for \$40 a year by the Ohio State Medical Association, 3401 Mill Run Drive, Hilliard, Ohio 43026. Periodicals postage paid at Hilliard, Ohio and at additional mailing offices. POSTMASTER: Please send address changes to *Ohio Medicine*, 3401 Mill Run Drive, Hilliard, Ohio 43026.

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Colleagues

Newsmakers

JAMES CARR, MD, Cincinnati, was inducted into the Junior Achievement Business Hall of Fame. Each year, Junior Achievement of Greater Butler County honors individuals who have contributed greatly to the well-being of the community by inducting them into the Business Hall of Fame, established in 1989.

STEWART B. DUNSKER, MD, Cincinnati, was elected the 1999-2000 president-elect of The American Association of Neurological Surgeons (AANS) at the AANS annual meeting

in New Orleans, Louisiana in April. Dr. Dunsker is professor of clinical neurosurgery and vice chair of the Department of Neurosurgery at the University of Cincinnati, where he also holds appointments as the director of the Division of Spine Surgery and adjunct associate professor of anatomy. Dr. Dunsker is a past president of the OSMA.

WILLIAM J. GERHARDT, MD, Cincinnati, received the 1999 University of Cincinnati College of Medicine Distinguished Alumni Award. The award recognizes alumni for their outstanding leadership and significant contributions in the health field.

GARY KIRSH, MD, Cincinnati, board member for the Urology Group, has been appointed to the board of the American Association of Clinical Urologists.

THOMAS H. MALLORY, MD, Columbus, an orthopedic surgeon, has been named chair of The Ohio State University College of Medicine and Public Health's newly formed Department of Orthopedics. Dr. Mallory also was named to the Frank J. Kloemeier chair in orthopedic surgery. Dr. Mallory is founder of Joint Implant Surgeons Inc. of Columbus, and is a leader in the use of technologically-advanced procedures for hip and knee replacement surgery.

thought, why not bring Riverside Hospital to the zoo?" Dr. Baird says.

A partnership between the Columbus Zoo, Riverside and Children's Hospital was formed. In February, a team from the three groups performed an emergency Caesarean section on a pregnant gorilla who had developed toxemia. The healthy baby girl gorilla was named Kambera Dupe - Kambera from initials of those involved in the delivery; Dupe the African word for "young."

Dr. Baird has traveled extensively with Hanna in a medical advisory capacity and has appeared on *Good Morning America* with the zoo's twin baby gorillas. While in Uganda, with little medical equipment, Dr. Baird relied on his senses and instinct to provide medical attention to a woman who had developed an infection after giving birth. The incident underscored the lack of physicians in rural areas, and the amount of people living in those areas who have never seen a doctor. A situation Dr. Baird hopes to change. — *Pamela J. Willits*

Portrait

Columbus obstetrician James Baird, MD, new director of the Ohio Department of Health, has experience that spans the globe, and even the animal kingdom.

Having served as an obstetrician for 27 years and as senior vice-president and chief medical officer of OhioHealth since 1993, James Baird, MD, has sought new challenges while striving to have a positive influence on health issues.

Director of the Ohio Department of Health is his most recent challenge. "My image was that the department was a regulatory, bureaucratic organization," admits Dr. Baird. "Then I discovered the work they do and realized there was an opportunity to affect a greater number of people in terms of health issues than I could in the private sector," he states.



James Boaird,
MD

Obituaries

CHARLES W. BARCH, MD, Columbus, OH, Ohio State University College of Medicine, Columbus, 1938; age 85; died April 14, 1999.

PAUL C. BOYD, MD, Findlay, OH, Dalhousie University Faculty of Medicine, Halifax, 1976; age 49; died March 17, 1999.

DARRELL C. CAUDILL, MD, Lutz, FL, Ohio State University College of Medicine, Columbus, OH, 1941; age 83; died March 18, 1999.

JAMES B. DALEY, MD, FACS, Fairview Park, OH, St. Louis University School of Medicine, St. Louis, 1943; age 81; Feb 17, 1999.

HORACE B. DAVIDSON, SR, MD, Columbus, OH, Ohio State University College of Medicine, Columbus, 1933; age 88; died April 8, 1999.

ROBERT E. FULTZ, MD, Cincinnati, Medical College of Virginia Commonwealth University School of Medicine, Richmond, 1946; age 76; died March 19, 1999.

BARRY HORWITZ, MD, Dayton, University of Cincinnati College of Medicine, Cincinnati, 1965; age 62; died Feb. 28, 1999.

FRANK LEAKE, MD, Sandusky, OH, Johns Hopkins University School of Medicine, Baltimore, 1954; age 74; died April 13, 1999.

CHARLES R. MARLOWE, MD, South Pasadena, FL, Northwestern University Medical School, Chicago, 1937; age 90; died April 22, 1999.

WIE T. PIEN, MD, Chardon, OH, Mukden Medical College, Mukden, 1948; age 72; died April 2, 1999.

A.E. RODIN, MD, San Diego, University of Manitoba Faculty of Medicine, Winnipeg, 1950; age 72; died March 18, 1999.

NORMAN L. STRAW, MD, Shelby, OH, University of Cincinnati College of Medicine, Cincinnati, 1952; age 78; died March 13, 1999.

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Bills, Laws & Rules

PIE fallout

OHIC sues Guaranty Association

OHIC Insurance Co. says the fund created to protect it is tapping its resources instead. It wants the Supreme Court to change the way funds are paid by the guaranty association.

OHIC Insurance Company, a Columbus-based medical malpractice insurer, has filed suit against the Ohio Insurance Guaranty Association (OIGA), claiming that its method of paying claims is placing an undue financial burden on the company. The suit stems from the failure of PIE Mutual Insurance Company.

When an insurance company goes into liquidation, OIGA steps in and assumes responsibility for the resolution of that company's claims until the liquidation is complete. OIGA, which is

funded by assessments on Ohio-licensed insurance companies, pays a maximum of \$300,000 per claim per policy, excluding the legal costs associated with the defense of the claims. In addition, both insureds and claimants must first exhaust all other available coverage prior to collecting from the OIGA.

As a result, if two physicians are named in a malpractice suit, and one was a PIE insured, the insurer of the other physician must first exhaust the limits of that physician's coverage before OIGA would step in. OHIC claims in its suit that this not only has a dire financial impact on the other insurer, it also has a chilling effect on the settlement of claims. Typically, 95% of all malpractice suits are settled before reaching court.



Reg update

Impaired physicians rules proposed

The medical board adopted new rules for impaired physicians and other healthcare professionals. The new rules:

- Require that an impaired physician receive 28 days of inpatient treatment.
- Redefine relapse to include efforts to obtain drugs for personal use.
- Mandate a suspension of at least 90 days for a first relapse, the suspension is two years.
- Require reporting of all relapses. Self-reporting also is required.
- Require a 72-hour inpatient examination for all approved treatment providers. The exam may be board mandated or privately referred.
- Impose a probation of at least five years duration. No modifications to the probation may be made during the first year.
- Allow 30 days for the physician on probation to find a supervising and a monitoring physician. Probation is lengthened if the physician dawdles.

— Jan Leibovitz Alloy

OSMA involvement

The OSMA House of Delegates dealt with this issue at its Annual Meeting in May. Resolution 22-99 asked that the OSMA attempt to change the exhaustion requirement imposed on carriers. After lengthy debate, the House referred the resolution to the OSMA Council for decision.

The Council has not yet had the opportunity to review this matter. Watch future issues of *Ohio Medicine* for further developments on this subject. ■

Take Action

If you have questions about this suit, contact Nancy Gillette, JD, Division of Legal Affairs, (800) 766-6762, Ext. 6767.

January Medicare payments to be delayed

Continued from page 1

HCFA instructions, and the processing will be done correctly." Nationwide declined to comment on January catch-up plans.

Medical offices should file claims as they normally would. Claims with service dates prior to Jan. 1, 2000, received between Jan. 1 and Jan. 17 will be processed normally. Use existing instructions to determine if medical services that occur in both 2000 and a prior year may be broken up into separate claims, so that the portion performed during 1999 (or a prior year) can receive earlier processing at the appropriate payment rates. If you do not break up a claim for services that were performed in both 2000 and a prior year, the entire claim will be held until released Jan. 17.

Several Ohio medical-practice management firms have notified their clients about possible delays in Medicare payments beginning in late January or early

February. "We normally receive clients' Medicare payments about 21 days from Medicare's date of receipt," said Jeffrey T. Russell of Ohio Heart Care, business manager for many Ohio cardiology practices, including that of OSMA President David J. Utak, MD.

"If claims in early 2000 are not going to be processed for 14 days," Russell said, "it would be logical to assume that payments at some point will be delayed, creating a 'cash hole' for physicians. The size of this 'hole' is dependent upon the promptness with which HCFA processes the claims backlog and other factors, including the possibility of a 'log jam' for which there is precedent."

"Receiving interest on the late payments isn't the answer most physicians will want to hear. According to Medical Group Management Association statistics, Medicare amounts to 25% to 60% of individual practice receivables.

"It is possible that for some physicians, a delay in Medicare payments at that time of year will be intolerable, since physicians also experience some additional expenses then, such as payroll-related taxes, certain insurance expenses, and some bonus payments. Normal cash slowdowns also occur with annual patient deductible spend-downs.

"Some specific assurances of additional computer and human resources allocated to this delay would be helpful. Optimally, the planned delay would be cancelled."

Filing electronically, according to Ohio Heart Care's Russell, improves payment turn-around by up to three days. He advises, "Prepare your practice for this and other Y2K-related problems by reserving additional cash and obtaining bank lines of credit to help the practice weather any cash flow shortfalls."

Part A providers will not be affected,

as their annual payment updates occur on Oct. 1 of each year. — Carol Larimer

Take Action

According to the AMA, the HCFA year-end plans are not set in stone at this point. OSMA strongly urges members to contact their Congressional representatives and urge them to oppose HCFA's proposed payment delay. If you need the names of your representatives, contact the OSMA Department of Legislation, (800) 766-6762, or check the OSMA Web site, www.osma.org, under the legislation section. The OSMA has also prepared a sample letter you may copy and send or use as a model for your own letter. To obtain a copy, contact the *Ohio Medicine* reader response line, (800) 766-6762, Ext. 6580, and ask for item #18-99.

Board actions posted on Web site

The State Medical Board of Ohio is now publishing its "Monthly Formal Action Lists" on its Web site (See "Links" section of the OSMA Web site, www.osma.org). The list presents a summary of the board's actions, including: citations/proposed denials; final orders; pre-hearing suspensions; consent agreements; voluntary surrenders/retirements; reinstatements; modified probation; probation terminated; and court actions.

Medical Board Report

Physicians are listed by name, MD/DO number, and city. The listing is found under the "Information for

Consumers" heading. Also new to the site is a button that allows consumers to look for physicians in their area by specialty, county, or a combination of the two.

Of course, physicians may also use the board's Web site to check on licensure and CME requirements. See the site's "Information for Practitioners" heading.

Position papers to be revised

The board's Education, Public Relations and Risk Management Committee has started the process of revising old position papers. Three papers have already been singled out - the board positions on acupuncture, cebolan therapy, and hypnosis. The committee will gather the latest information on these topics, and update each paper accordingly. ■

Rural hospitals may now employ physicians

Legislation changes quickly. Check the OSMA Web site, www.osma.org, for the latest status of health-care bills.

Senate Bill 56, which allows rural hospitals to employ physicians, has passed the Legislature and will become Ohio law in mid-September.

The bill, sponsored by Sen. Doug White (R-Manchester), follows close on the heels of a similar bill that passed last session, Senate Bill 31. SB 31 abolished the ban on the corporate practice of medicine, but it also included a provision that protected the physician's professional, clinical judgment with respect to patient care.

Similar language was built in SB 56, thanks to the efforts of the OSMA. Although rural hospitals may now hire physicians as employees, they are prohibited from controlling the physician's professional, clinical judgment when used within the accepted prevailing standards of care.

Rural hospitals, incidentally, are defined as those facilities in counties with populations under 125,000. Under that definition, hospitals in 69 Ohio counties may now hire physicians.

The OSMA's position on the bill was neutral with technical assistance.

Bills passed:
Handicapped parking violators

Bill tracker

face stiffer fines...When House Bill 148 passed the Senate, it set into law new, increased penalties for those who violate the special parking privileges established for the disabled. It also makes changes in the application process for removable windshield placards. Now, patients who need placards will first have to receive a prescription for them from their physician, and there will be penalties imposed on physicians who either knowingly prescribe placards to those who don't need them, or who prescribe placards beyond the patient's recovery period.

Students with asthma may now carry inhalers...House Bill 121 has passed the Legislature and is en route to the governor for his signature. The new law will permit students of school districts, community schools and chartered nonpublic schools to carry asthma inhalers approved by the students' physicians and parents and grants immunity to school districts for good faith actions in connection with this permission. The bill was sponsored by Rep. Randall Gardner (R-Bowling Green) and was supported

by the OSMA.

State guards against future tobacco settlements...Although most tobacco manufacturers have an agreement with State Attorney General Betty Montgomery, as part of the national tobacco settlement, the Legislature wanted to make certain that those tobacco manufacturers not included in the agreement are still held responsible for any future tobacco judgment or settlement that may arise. So, the Legislature passed House Bill 362 which requires a tobacco product manufacturer who sells cigarettes in Ohio but is not part of the tobacco settlement agreement, to place specified amounts of money into a qualified escrow fund annually. That fund will then be used to pay any future judgment or settlement on a claim brought against the manufacturer regarding tobacco products. The bill was sponsored by Rep. Kevin Coughlin (R-Cuyahoga Falls). The OSMA had not considered the bill.

Bills introduced:

Bill requires physician profiles...If passed, Senate Bill 154 would require the State Medical Board to create physician profiles, and to make those profiles available to the public. It's sponsored by Sen. Robert Hagan (D-Youngstown). At press time the bill

had not been formally introduced.

May, November could be cancer awareness months...Senate concurrent resolutions 21 and 24 are designed to increase Ohioans' awareness of different types of cancer. SCR 21, sponsored by Sen. Grace Drake (R-Solon), would designate May as melanoma/skin cancer detection and prevention month - and SCR 24 names the month of November as pancreatic cancer awareness month. The latter resolution is sponsored by Sen. Rhine McLin (D-Dayton).

Bills updated:

Budget bill keeps boost for Medicaid providers...Good news for Ohio's Medicaid providers. The \$124 million in funding to boost reimbursement levels for Medicaid service providers was preserved in the final version of the budget bill. What was not preserved, however, was a provision that would have permitted smaller hospitals to perform heart catheterization treatment for high-risk patients. The provision would have allowed more than 30 hospitals to perform cardiac catheterizations in facilities that lack open-heart surgery backup.

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Colleagues at the Statehouse

OSMA president-elect testifies on APN bill

OSMA President-Elect Walter Wielkiewicz, MD, Zanesville, testified at the Statehouse in June on House Bill 241, the legislation that, if passed, would grant advanced practice nurses (APNs) prescriptive authority.

Dr. Wielkiewicz told the House Health Committee that the OSMA is uncomfortable with a provision in the bill that allows APNs to practice as long as they are within four hours driving distance of the supervising physician. Dr. Wielkiewicz told legislators that an hour's drive time, as specified in the Physician Assistant statute, would be more appropriate. Tom Dilling, representing the State Medical Board of Ohio, testified along the same lines.

Dr. Wielkiewicz also suggested that APNs be required to have a master's degree in order to have prescriptive authority. Dilling added that the medical board was not yet ready to support the measure.

Other OSMA members who have testified recently include:

Sally Abbott, MD, Springfield
Testified: In opposition to HB 241, prescriptive authority for Advanced Practice Nurses.

Mary Applegate, MD, North Canton
Testified: In support of HB 241, prescriptive authority for Advanced Practice Nurses.

James A. Bryant, MD, Miamisburg
Testified: With regard to HB 218, infant formula. He explained programs operated by the Department's Bureau of Children with Medical Handicaps which provides assistance to qualified families to obtain special formulas.

John A. Burkhardt, MD, Columbus
Testified: In opposition to direct access to physical therapists, a

provision of HB 305.

Represented: OSMA

Charles Casto, MD, Akron

Testified: In support of HB 261, health insurance liability. (This bill repeals the scheduled repeal of the law establishing qualified immunity for providers of free health-care services to the indigent.)

Represented: Akron Free Clinic

Richard Gordon, MD, Springfield

Testified: In opposition to HB 241, prescriptive authority for Advanced Practice Nurses.

Ted Grace, MD, Columbus

Testified: In support of HB 241, prescriptive authority for Advanced Practice Nurses.

Jawahar Palaniappan MD, Mount Vernon

Testified: In support of a House amendment to the state budget bill (HB 283) that allows smaller hospitals to perform low-risk heart catheterizations.

Dwight Scarborough MD, Columbus
Testified: In support of SCR 21, skin cancer awareness month.

Represented: The Ohio Dermatological Association

S.R. Thorward, MD, Columbus

Testified: In support of HB 53, mental health parity

Represented: OSMA and the Ohio Psychiatric Association

David Westbrock, MD, Dayton

Testified: In support of SB 130, which requires the pharmacy board to establish a list of drugs that may be hazardous when different brands or generic equivalents are interchanged.

Represented: American Association of Clinical Endocrinologists

APNs a step closer to prescribing

Before it passed, OSMA successfully added to HB 241 a physician-to-nurse ratio, and removed portions that called for expanded scopes of practice for nurse midwives.

The OSMA's strategy, adopted by the House of Delegates in May, to repeal its opposition to Advanced Practice Nurse (APN) prescribing in exchange for a seat at the negotiating table has worked. The bill, which, this year, seemed to be inevitably hurtling toward passage, has been tempered to a great extent by the OSMA's efforts. For example, the OSMA helped:

- Establish an APN-to-doctor ratio. When the bill passed the House at the end of June, it contained an amendment, suggested by the OSMA, that set an APN-to-collaborating-physician ratio. Prior to this amendment, the bill contained no ratios, oversight (other than by the state's Board of Nursing), or any kind of quality assurance requirements. Although OSMA House of Delegates policy calls for a 2:1 ratio, a last-minute compromise struck by the committee increased that number to 3:1.

• Assure physician input.

Another significant change to the bill, again prompted by the OSMA, was the establishment of a joint physician/APN committee. This group will write rules for formularies, and the rules must include, according to the bill, specific requirements for periodic chart reviews, quality assurance, and travel time for the supervising physician.

• Limit drugs to be prescribed.

As originally introduced, HB 241 would have permitted APNs to prescribe from a formulary specific to their specialty, including drugs in schedules II-V. As passed, the amended bill limits APNs to a formulary restricted to drugs in schedules III-V.



Remove expanded practice scope.
HB 241, as originally drafted, would have allowed nurse midwives to perform obstetrical surgical procedures and to deliver breech and face presentation infants. The OSMA was successful in having these provisions stripped from the bill.

The legislation now heads to the Senate, where committee work is not expected until fall. However, OSMA has continued to work on the bill throughout the summer. Issues that still need to be addressed by senators this fall include:

- Whether prescribing nurses should be employed by their collaborating physicians (as OSMA policy suggests);
- How to "grandfather" in APNs who do not hold a master's degree;
- How to structure a fellowship program that would be required of all APNs prior to their obtaining a prescribing certificate.

The OSMA is grateful to all members who contacted their representatives regarding the need for a ratio amendment. The concerns of the OSMA were heard, and duly taken under consideration by the House. ■

Take Action

If you have questions, or would like more information about this bill, contact Marlo Eshelman Bump, OSMA Department of Legislation, (800) 766-6762, Ext. 6741.

Alternative medicine in curricula is shocking

To the Editor:

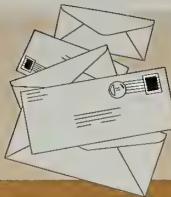
Ohio Medicine's June 1999 "In-depth Report" on alternative medicine and how it is being integrated into the medical schools is shocking.

In reading a wide variety of authors, including C. Norman Shealy, MD, PhD, Hans Holzer, PhD, along with the recently published *Fundamentals of Complementary and Alternative Medicine*, edited by Marc S. Micozzi, MD, PhD, it is evident that alternative medicine is known by a wide variety of names, including mind-body-spirit medicine, holistic medicine, energy medicine, complementary medicine, occult medicine, and the newer nomenclature of integrative medicine, indicating that eastern medicine (another term) is now being integrated with western medicine.

When I attended my 25th medical school reunion last year, a course was being taught on acupuncture, as well as other forms of alternative and complementary medicine. The lecturer on acupuncture, who happened to be a

gastroenterologist, described a system of healing that, in his own words, was not scientific and had absolutely no scientific base, but was nevertheless effective in keeping his patients healthy. He went on to describe how he transferred "energies" from one part of the body to the other, drained energies off the body, etc. He also showed numerous slides with the yin yang symbol prominently displayed. It is quite obvious that there is indeed a spiritual connection to this mode of "therapy" along with the other forms of "energy medicine."

The Dec. 14, 1998 *American Medical News* reported that moxibustion (burning Chinese herbs in acupuncture points) to turn the position of breached babies was found to be beneficial.



letters

Likewise, Chinese herbal medicine for irritable bowel syndrome was found to be statistically effective. Believe it or not, yoga was found to be effective for carpal tunnel syndrome.

The question to be asked is not whether or not these forms of "therapy"

are effective, but

rather, how do they work? If there is a claim of a statistic positive correlation between the burning of Chinese herbs on the mother's little toe and the subsequent fetal repositioning from the breach position, there must be some sort of extraneous force involved. That is what scares me. Indeed, Dr. C. Norman Shealy's book, published in 1975, entitled *Occult Medicine Can Save Your Life* warns that this force is occult. Other authors confirm this fact.

What constitutes alternative medicine? The National Institutes of Health in 1992 formed the Office of Alternative Medicine (OAM). Initially funded at the rate of \$2 million a year, its annual funding now exceeds \$50 million a year. The Office of Alternative Medicine has funded studies on the benefits of acupuncture in unipolar depression, osteoarthritis, post-operative oral surgery pain, and breast presentations. They have additionally funded studies on traditional Chinese medicine, Chinese herbal therapy, tai chi, qi gong, and many others. They have a complete listing of what is considered to be alternative medicine, which is subsequently subdivided into seven separate categories, and this complete listing is too extensive to be included here.

Shouldn't the Ohio State Medical Association and Ohio medical schools be labeling this type of "therapy" for what it is - occult?

Kenneth D. Christman, MD
Dayton



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Dateline: Ohio

Ohio doctor indicted for Web prescribing

About a week after filing a lawsuit against the State Medical Board of Ohio and the Ohio Board of Pharmacy to force a court ruling on Internet prescribing, Daniel L. Thompson, MD, Dublin, was charged with prescribing dangerous drugs over the Internet.

He was indicted by a Franklin County grand jury on 64 counts of selling dangerous drugs and drug trafficking. Three companies through which Dr. Thompson allegedly prescribed the drugs were indicted on seven similar charges.

Currently, there are no regulations or laws prohibiting Internet prescribing, however, the medical board approved draft rules earlier this year concerning Internet prescribing. It's expected that the board could adopt the rules soon, once they receive approval from the state Joint Committee on Agency Rule Review. The proposed rules state that minimal standards call for a physician to examine patients and make diagnoses before prescribing controlled substances.

The Franklin County prosecutor, said doctors who don't meet minimal standards of care, which includes examining patients before prescribing controlled substances, could be subject to criminal charges. Under Ohio law, selling a dangerous drug for retail is a fourth-degree felony. The criminal charges brought against Dr. Thompson are fourth- and fifth-degree felonies. A fourth-degree felony carries a prison term of up to 18 months, while a fifth-degree felony carries a prison term of up to a year.

Internet prescribing has become popular because customers don't have to discuss embarrassing conditions in person. Dr. Thompson is accused of illegally selling a number of these so-called "embarrassment drugs," including Viagra, Propecia, and the diet drugs phenetermine and Meridia, both controlled substances. ■

OSMA News



What AMA's collective bargaining decision means to you

The AMA's decision to develop a collective bargaining unit for physicians may help to level the playing field for the profession in today's managed-care environment, but what exactly does this mean to you?

Who will be affected?

An affiliated national labor union, such as the one the AMA plans to implement, is not for all physicians. At least not yet. (See next item.) Currently, you may only take advantage of a collective bargaining unit if you are employed by an:

- Physician-owned group;
- Hospital;
- Medical school and/or university;
- Local and state government;
- Ambulatory site.

Who will not be affected?

If you are a self-employed physician, you are still prohibited by federal law from negotiating collectively with health plans. The only way this will change is if Congress acts to address this issue by repealing the federal anti-trust laws, or if individual states, through a state action doctrine, acts to allow physicians to collectively bargain.

Will the two conditions that would allow collective bargaining ever become a reality?

Yes, there is a good possibility right now. Both the AMA and the OSMA, in addition to other health-care groups, are actively supporting a congressional bill, House Resolution 1304 sponsored by Rep. Tom Campbell (R-CA), that would allow physicians to negotiate contract terms and conditions with health insurers. It's currently pending before the House Judiciary Committee. The AMA and OSMA urge you to

contact your congressional representative immediately to voice your support of this bill.

The second condition to enact a State Action Doctrine, isn't as likely a possibility, but it's not remote, either. Texas recently enacted such a doctrine to allow its state's physicians to collectively bargain with health plans.

Will residents be able to use the AMA labor union?

Residents who train in Ohio hospitals are employed by the hospitals, and, as such, are eligible to become part of the AMA's collective bargaining unit.

Assistance to residents, however, may also come when the AMA develops its Independent Housestaff Organizations for residents. These organizations would allow residents to voice their concerns regarding patient care and resident quality of life issues to institutional leaders.

Will collective bargaining focus on reimbursement rates?

Reimbursement rates are just one of many issues physicians would like to address with health plans. Also on the table will be such issues as:

- Lack of physician input into medical policy;
- Incorrect medical necessity determinations;
- Abusive business practices, such as late payments and inefficient utilization controls;
- Drastic, unsupportable reductions in reimbursement rates.

Is collective bargaining really necessary?

The fact that the AMA House of Delegates addressed this issue at all is strong evidence that some leveling of the playing field is in order. Acting alone, an individual physician has little

power to convince plans or employers to change unfair policies and procedures, especially if the community is dominated by one or two major payers. Physicians who decide not to participate in these plans often risk financial ruin because the community's population is often concentrated in these plans. Yet, if a physician chooses to take the risk and elects not to participate in a plan, his or her decision has negligible impact on the plan itself. Because of their dominance in the marketplace, these plans almost never negotiate with individual physicians and, individually, physicians have little recourse. They need the leverage of a large group in order to have more power in determining their relationship with health insurers. The bottom line for all physicians is to improve patient care. As the marketplace has evolved, it may now be necessary for physicians to resort to collective bargaining so that they have more control over the physician-patient relationship.

What happens now?

The AMA says it will waste no time turning the delegates' mandate into reality. The AMA board has already met on this issue and has outlined initial steps it will take to implement this collective bargaining unit. Continue to watch *Ohio Medicine* for future developments on this important issue. ■

OSMA happenings...

Court dismisses OSMA-OHA lawsuit...A judge in the Ohio Court of Claims dismissed the lawsuit filed jointly by the OSMA and OHA: The Association for Hospitals and Health Systems against the Ohio departments of Insurance and Human Services. The suit alleged that the departments did not monitor the financial condition of Personal Physician Care, which was liquidated by the ODI in August. In its ruling, the court said the state can't be held liable for failing to monitor a managed-care company. The OHA and OSMA will appeal the court's decision.

Domestic violence material sent to counties...Local health departments and county medical societies will receive the domestic violence screening tool sent to OSMA primary care members last month, as part of the *TrustTalk* package on domestic violence – component two in the five-part OSMA Women's Health Initiative project. In addition, the groups will also receive a listing of medical and public health agencies that work to end the cycle of domestic abuse in their specific counties. The material is made available through a Robert Wood Johnson Foundation grant, awarded to the OSMA and the Ohio Public Health Association, which is working jointly on the domestic violence projects. County societies and health departments have been encouraged to share information on how they, working with other public health partners in their community, are addressing the problem of domestic abuse. Watch future issues of *Ohio Medicine* for their stories.

OMERF Leadership Awards distributed...Each year, the OSMA's Ohio Medical Education and Research Foundation (OMERF) presents medical scholarships to qualifying students at each of Ohio's medical schools. This year's recipients are: Julie Christine Burridge, University of Cincinnati College of Medicine; Manoshi Bonnie Dutta, Medical College of Ohio at Toledo; Cynthia Eileen Lavery, Ohio University Col-

Continued on page 13

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President's Perspectives

What happens after Annual Meeting?

As you know, every May, OSMA delegates from around the state gather together to consider resolutions and set the association's policy for the coming year. But what happens to all those adopted resolutions once the meeting is over?



Dr. Utak

I can assure you that they are not filed away on a shelf, forgotten. Instead, some of them are sent on to council, some to the Ohio delegation, and a majority of them are forwarded to appropriate OSMA staff members to implement on our behalf.

For example, consider Amended Resolution 15-99, Standards for Advanced Practice Nurses and Physician Assistant Prescriptive Authority. This resolution changed OSMA policy with regard to prescriptive authority for APNs. Immediately following our meeting, the physicians and OSMA staff who are negotiating this bill were able to play a much more active role in putting safeguards in legislation that seemed destined to pass.

Also consider Emergency Resolution 03-99, Training Certificates for Residents. This resolution called on the OSMA to request the State Medical Board of Ohio to consider a reasonable delay in the imposition of the new requirements for training certificates for residents. Shortly after the meeting, a lengthy letter was sent from the OSMA (and the directors of seven university and hospital medical education departments) to the State Medical Board, requesting the delay. We provided the board with a number of valid legal reasons why a delay was warranted. Unfortunately, the board has decided to proceed with its implementation despite

continued on next page

What happens

continued from page 11

our request, but the OSMA did what delegates asked of it in May.

At the AMA Interim meeting in December, AMA delegates will receive information about the OSMA kit that educates students about the hazards of tanning. That will be in response to Resolution 30-99, submitted by the Ohio Dermatological Association as well as the Butler County Medical Society, urging the AMA to develop a nationwide program that encourages county medical societies to work with the various schools in their county to include information in their health curriculum about the hazards of tanning.

And, in future issues of *Ohio Medicine*, you will be able to find information regarding the ratings of health maintenance organizations. That's because of Emergency Resolution 12-99 that asked the OSMA to gather information on patient and provider ratings and to publish this information for its members, as well as the public. The malpractice carriers ratings report that now runs quarterly in *Ohio Medicine* is the result of a resolution that passed at last year's Annual Meeting.

My point is that OSMA continues to be responsive to the changing needs of our present health-care environment. From delegates who identify issues and craft them into resolutions, to the House which considers each of these resolutions democratically and with due respect, to the staff who put our ideas into action, the OSMA is making a difference in the lives of Ohio physicians, and, more important, in the lives of our patients.

For two days in May, we are energized by the act of gathering together as one body, organized medicine, capable of accomplishing great things together. I just want you to know that, once Annual Meeting adjourns for another year, the momentum continues through your officers, your council, and the staff of the OSMA. We continue to work to achieve your ideals. ■

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Continued from page 10

lege of Osteopathic Medicine; Eric Jude Ley, Ohio State University College of Medicine; Kurtis Neal Stemple, North-eastern Ohio Universities College of Medicine; and Maurice Edgar Young, Wright State University. Congratulations to all the scholarship recipients.

Trumbull County Medical Society names new exec...The Trumbull County Medical Society has named a new executive director. She is Lynda Graham, and she can be reached at TCMS, 108 Main Ave., SW, Suite 902, Warren, OH 44481.

Dr. Polsley wins AMA post

OSMA member J. Steven Polsley, MD, Urbana, has won his bid for seat on the AMA Council on Medical Service. His term will run through 2003. The AMA Council on Medical Services deals with the complex issues of health-care finance, access to care and quality of service. Dr. Polsley, president of a six-person family practice group, deals daily with contract negotiations and compliance issues with managed-care regulations which will qualify him for his new position. ■



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Federation of Medicine

From the county files ...

MCMS puts its members on the line

Next month marks the first anniversary of *Doctor-on-Line*, a weekly radio show sponsored by the Montgomery County Medical Society (MCMS) in Dayton. The talk show broadcasts live every Saturday and repeats the following Wednesday.

Each show covers a single topic. A host and, usually, two physicians with expertise in the area discuss the topic and take call-in questions and comments from listeners. "We found out very quickly that having two doctors in the room to discuss the subject kept it going very nicely," says communications director Gerri Creel. "It gives you a balance of feedback and ideas on the subject."

To get things going, the featured physicians arrive with their own list of 10 to 12 questions to answer. "That usually fills the half hour," Creel says. "They're the specialists in their field and they know what kind of information is most appropriate to be shared in this kind of a setting. It also gives

them a sense of knowing something won't be coming out of left field. They have a sense of control over how the program goes."

MDs as emcees

For the first few months the show was hosted by a professional broadcaster. But the society's communications committee decided members would be better moderators. Now, five physicians alternate as host:

- Deepak Kumar, MD, a colorectal surgeon and president of MCMS;
- Scott Nekrosius, MD, a psychiatrist;
- Ron Warwar, MD, an ophthalmologist;
- Dan Whitmer, MD, a family practitioner; and
- Dave Westbrook, MD, an endocrinologist.

The society originally wanted to broadcast a television program, Creel says, but the cost was prohibitive for a

show that would only air once a month. And the TV station wanted to choose the topics the show covered. "We didn't have free license to be in control of the programming the way we are with radio," Creel says. "It would have been working in tandem with an already established medical television program, and the committee had a sense that the TV station would still maintain control of the decisions about what was going to be aired."

No commercials

Doctor-on-Line airs on WING-AM, a commercial station. Although the station promotes the show seven or eight times each day, it schedules no advertising during the show. "We at first thought that we would need to develop PSAs to make breaks," Creel says. "But it's better not to interrupt it. If you get a couple of call-ins, that takes up that half hour of time nicely." As a prompt to listeners, the society gives away *Doctor-on-Line* T-shirts for the

first two calls each week.

The interest and response of physicians for the show has been phenomenal, Creel says. Despite having to clear time on a Saturday morning, most readily accept the invitation to appear on the program.

Upcoming shows include discussions on back-to-school health, hospitalists, chronic fatigue, and hyperbaric oxygen treatment. — *Jan Leibovitz Alloy*

Take Action

"From the county files..." is designed to show how county medical societies are identifying and responding to issues in their areas with programs and activities that you may wish to borrow for your county. If you would like more information about the programs mentioned here, contact Connie Mohle, executive director, Montgomery County Medical Society, (937) 223-0990.

AMA Report

OSMA resolutions do well at AMA

Of the resolutions sent by the OSMA House of Delegates to the AMA Annual Meeting in June, three were adopted, one was referred to the AMA Board of Trustees, and one reaffirmed current AMA policy.

The three adopted resolutions included AMA resolution 168, AMA Implementation of a National Collective Bargaining Unit (OSMA resolution 52-99); AMA resolution 140 (OSMA ER 13-99), Credentialing of Physicians by HCFA, and the AMA resolution 235 (OSMA 25-99), Retirement Plan Legislation.

The first resolution adopted by the House calls for the AMA to immediately implement a national labor organization under the National Labor Relations Act, to support the develop-

ment and operation of local negotiating units as an option for employed physicians, as well as for fellow and resident physicians who are authorized under state laws to collectively bargain. Further, the resolution calls for the AMA to support antitrust relief for physicians by actively supporting legislation like the Campbell bill, which repeals federal antitrust laws. OMSS board member Ted Jones, MD, Cincinnati, chaired the AMA reference committee which made the recommendation to the AMA House.

The second resolution (OSMA ER 13-99) calls for the AMA to vigorously oppose efforts by HCFA, as illustrated by rules governing hyperbaric oxygen therapy practice, that dictate specific physician credentialing, privileging and continuing medical edu-

cation requirements. The AMA House said such matters are better left to hospital medical staffs and medical licensing boards.

The third adopted resolution (AMA resolution 235/OSMA 25-99) asks that the AMA focus a lobbying coalition with other affected groups to vigorously support legislation that would raise allowable pension plan contributions and index, subsequent to increases to inflation.

AMA resolution 427 (OSMA 29-99) was reaffirmed by the AMA House. Specifically, the resolution calls for the AMA, in cooperation with the AMA Alliance, to become knowledgeable and active grassroots advocates for effective tobacco control legislation at local, state and national levels.

Finally, AMA resolution 618

(OSMA 63-99), asks that the AMA Task Force on Membership work with all components of the Federation, along with specialty societies, to develop a global billing statement which includes significant financial incentive for membership in all levels of the Federation and designated specialty.

These resolutions were brought before the AMA House by members of the Ohio delegation, chaired by Walter Reiling, MD, Dayton. Additional OSMA resolutions are slated to be brought before the AMA House at its interim meeting in December.

In other business at the AMA's June meeting, J. Steven Polstey, MD, was elected to the Council on Medical Service (See story on page 13.) ■

Alliance Report

Working together in the new millennium

The following has been excerpted from the inaugural address, given by OSMA's new Alliance President Jan Kirlin.

My theme for this year is "working together in the new millennium." The challenges facing our society are many, and these changes will have a significant impact on the lives of physicians and their families in the coming years. As we face these changes, we in the Alliance must remember to work together in close partnership with every medical organization to enable each group to benefit from each other's strength.

Just as physicians are the minds, voices, hands and the heart of American medicine within our communities, our state and our county, the Alliance stands ready to be the arms and legs of American medicine – those who help set the physician's goal in motion. Working together in the new millennium, we can be their public relations arm, connecting physician and spouses to schools, libraries, health and social organizations and community leaders. The Alliance is impacting our community in a very positive way, whether in our health promotion efforts or in the legislative area.

Working together, we can raise funds for medical education and research through the AMA foundation. Working together, we are ready to rally grassroots support on legislative priorities. We have to educate our members as to what is happening legislatively, hoping that they will become active once they know the issues. We know two issues most important to health consumers: 1.) a choice of doctor and 2.) the ability of their doctor to make the decisions necessary in their health care. The Alliance is fighting to keep

Medicare strong, to limit government intrusion, and to preserve the doctor-patient relationship. Today, health care is at a turning point. We need to take our responsibilities more seriously than ever before.

Working together, we need to address the issue of violence in our society. Our Alliance has made an impact on family violence. Children must learn in as many ways as we can teach them that hands are not for hitting, not for bullying, not for shooting.

Working together, we need to join hands in new campaigns against tobacco. Every day, 3,000 of our children light up their first cigarette. Most are between the ages of 11 and 14 years.

The Alliance has a critical role to play supporting the medical profession, protecting public health, and helping people to see the caring, devoted face of American medicine we know so well. The Alliance mission is to be a support network for physicians' spouses and to keep members and their communities informed of the challenges facing medicine, the physicians and their families. One by one, working together in the new millennium, we can make a difference. ■

Jan Kirlin, is the OSMA Alliance president.

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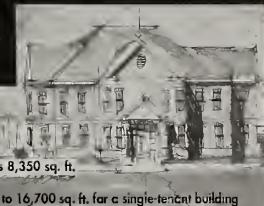
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On the Web...

Are you ready for Y2K?

No one can predict for certain what will happen on Jan. 1, 2000, but it's imperative that physicians work to correct any computer glitches that might occur in their practice or have contingency plans in place in case their systems fail.

The OSMA has prepared a *Y2K Readiness Guide* that provides information that will help you identify problem areas, determine what to do and who to contact, implement changes and updates, and draw up a contingency plan. Information for the booklet was gathered from the AMA and the Health Care Financing Administration. The booklets are available free to members; nonmembers pay \$10. You can order a kit online from the OSMA Web site (www.osma.org) by going to the "Membership Information" section and clicking on "OSMA store" or call Robin Parker, Division of Public Affairs, (800) 766-6762, Ext. 6744.

A new page on the OSMA Web site, called "Y2K Readiness," contains information the OSMA believes will be

of interest to its members. Occasionally, you may find a few horror stories or humorous ones related to Y2K testing as well.

The Y2K Readiness section of the Web includes a list of state-specific resources complete with phone numbers and Web site addresses.

According to the OSMA Web site Y2K pop-up survey conducted in May, most of our members are in pretty good shape. The majority of members have already conducted a review of their office systems to determine if their office is prepared for potential problems that may occur in the year 2000. However, when asked "if the office staff had taking advantage of offers from payers to test your billing system against theirs," many responded they were unaware of these offers.

For any Y2K questions you may have, e-mail Todd Baker, OSMA Division of Public Affairs, at tbaker@osma.org or call him at (800) 766-6762, Ext. 6734. ■

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Practice Tips

Flu season

New immunization codes likely to create confusion

Vaccine products are playing a key part in the CPT's new immunization codes. Now you need both an administration code, and a code for the specific immunization product.

When the CPT immunization section for 1999 was released, a number of changes had been made: new codes were added, some of the frequently-used ones deleted, and the terminology on most of those surviving revised. These changes have been prompted by the need to meet the reporting requirements of immunization registries, vaccine distribution programs and reporting systems. Multiple codes for particular vaccines have been added to help distinguish between the number of doses and/or the possible timing differences for the same vaccine, chemical formulation, and route or administration.

Vaccine products are now taking a key role in these immunization codes, so physicians and other health-care providers must report both an administration code and a code for the specific immunization product given to a patient.

Don't unbundle combo vaccines

According to the new guidelines, the combination vaccines can't be unbundled. If a specific vaccine code is not available for a particular vaccine, or combination vaccine, the unfisted procedure code 90749 should be used until a new code becomes available. The same rule applies to the immune globulin products, and if there is no code for the exact product used, the unfisted code 90399 is the appropriate one to use.

Two new administration codes have

been added, and, according to CPT guidelines, these administration codes are to be used in addition to the E/M services provided on the same date "if a significant, separately identifiable E/M service is performed (modifier -25), as well as billing the code that identifies the vaccine or toxoid product indicated by CPT codes 90476-90749." These new administration codes must be reported in addition to the vaccine and toxoid code(s) 90476-90749, and are defined in the following manner.

90741 Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections and/or intranasal or oral administration); single or combination vaccine/toxoid.

90742 Two or more single or combination vaccines/toxoids.

For administration of Immune Globulins as defined in CPT codes 90281-90399, the following codes are used:

90780 IV infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; up to one hour.

90781 Each additional hour, up to eight hours. (List separately in addition to code for primary procedure.)

90782 Therapeutic or diagnostic injection (specify material injected); subcutaneous or intramuscular.

90783 Intra-arterial.

90784 Intravenous.

For intravesical administration of BCG vaccine, CPT code 90586 should be billed with CPT code 51720 (bladder instillation of anticancerogenic agent [including detention time]).

For a table linking the influenza virus vaccines available on the market with the proper CPT code see Take Action. On the influenza virus injections, if physicians aren't using the brand



Third party update

United HealthCare examines consult claims

Since June 1, United HealthCare has required that all claims submitted with consultation codes 99241-99425 be submitted with supporting documents. If supporting documents are not there, United HealthCare adjusts the claim to reflect an office evaluation and management service (99201-99215). According to the insurer's newsletter *Clipboard*, denials and adjustments of consultation codes can be appealed, but medical records are required, and it is the consultant's job, says the newsletter, to submit information needed to review the appeal. The OSMA Ombudsman Services Department is monitoring this situation. "We are not accepting UHC's conclusion that all physicians are not reporting accurate patient consultations, thus requiring all physicians to submit documentation with every claim," says Bill Fry, director of Ombudsman Services. The OSMA is in the process of discussing the situation with UHC staff, and will report its progress in a future issue of *Ohio Medicine*.



names specified, then the unlisted service code CPT 90749 should be used for billing. Administration code for flu is still G0008 for Medicare, and CPT 90741 for non-Medicare patients. ■

Take Action

If you have any questions about the coding changes for immunizations, contact OSMA Coding Specialist Jillian Phillips, MA, CPC, CCS-P in the Department of Ombudsman Services, (800) 766-6762, Ext. 6758. Questions may also be faxed to her attention, (614) 527-6763. If you would like a copy of a handout on this subject, which includes charts for *Hemophilus influenzae B* (Hib) conjugate vaccines; Hepatitis B vaccines; Hepatitis A vaccines; and CPT codes for products not yet FDA-approved, contact the *Ohio Medicine* reader response line and ask for item #20-99.

Ohio Employee Health Partnership launches pilot program. Only selected providers will be chosen to participate in the OEHP's new "Gold Card Provider Program," which will use utilization review and data outcomes to deliver "quality, cost-efficient medical services." OEHP is a managed-care organization, certified by the Bureau of Workers' Compensation to operate as part of its managed-care Health Plan Partnership program. Under OEHP's new pilot program, case managers will provide "concurrent management" with physicians to ensure that treatment follows approved C-9s. The advantage to the program, says OEHP, is that initial C-9s will be approved by OEHP in 24 hours.

Your Practice Guide

Chatroom speech may have lower standards

You may not be held responsible for every slanderous comment you make in a chatroom, but it doesn't hurt to be careful when you make statements on the Web.

When you create a Web site, you set yourself up as a publisher. Anything you say can and may be used against you. But can you be held responsible for every slanderous comment you make in a chatroom? So far, that's unclear, says attorney Carol Stovsky of Standley & Gilcrest in Dublin.

Although the definition may vary slightly from state to state, in general

- the qualifications for a finding of defamation require that a statement be:
 - Published in a way that relates to the plaintiff in the case;
 - Defamatory (libel if written, slander if spoken);
 - Substantially false;
 - Published with fault; and
 - Damaging to the plaintiff.

Chatroom libel uncertain

"When you get to a chatroom, and it's essentially a real-time communication," Stovsky says, "do you have publication?" Yes, but the publication is only to others participating in the chatroom and may be too limited to be damaging. "It's really like people who are in a room, or perhaps on a party line. With real-time communication, a number of people can hear what's being said, but it's not clear that you would be able to retrieve that statement or set of statements after the fact such that it would be considered published outside of the chatroom."

A statement sent via an e-mail list can be more easily pegged, so that libel laws apply. "Typically, people keep copies of e-mail messages, at least for some period of time," Stovsky says. "They can go back and look at it. You can see what the statement is. It's been written and it's retrievable."

Even if a chatroom comment is retrieved, it's likely stored in an indi-



vidual's computer, not where others might find it; the publication is still limited to the chatroom participants. "That's kind of like recording a movie when it's being broadcast so you can view it at a later time," Stovsky says. "Somebody might be doing it for his or her own personal benefit or convenience. So it is recorded but it's not quite the same as when you publish something on a Web site."

Slander another problem

Determining whether slanderous comments were made is another prob-

lem. "Maybe a potential plaintiff would say, 'I understand you had a big discussion about me last night, but what did everybody say?' You need to be able to analyze the statement that was actually made in order to decide if it was defamatory and substantially false and otherwise tarnishes the person's reputation or is a statement made to the person's discredit or otherwise meets the requirements. It's going to depend on whether the statement that was made in the chatroom was somehow captured." Otherwise the plaintiff must rely on chatroom witnesses to determine what was said.

And even if the statement was captured, since people often use screen names, it may not be possible to find out who made it. — *Jan Leibovitz Al-loy*

Take Action

For more information, contact Carol Stovsky, Standley & Gilcrest, (614) 792-5555.

Improvements to victim compensation program expected

Ohio physicians will see improvements in how they're compensated for treating victims of domestic violence and other crimes if current legislation passes.

compensation goes to eligible applicants, who then are responsible for reimbursing providers. "Of course, people aren't always responsible," says Lynn Cardwell, the program's public information officer. "And people who've been through a terrible experience tend to be less responsible. That's been a real problem for providers, particularly medical providers."

and cleaner

The Victims of Crime program is a payer of last resort for certain expenses for persons who are physically or emotionally injured or killed by violence. Under the current system, compensation goes to eligible applicants, who then are responsible for reimbursing providers. "Of course, people aren't always responsible," says Lynn Cardwell, the program's public information officer. "And people who've been through a terrible experience tend to be less responsible. That's been a real problem for providers, particularly medical providers."

Applicant must sign form

The best way to solve the problem is for the applicant to assign payment to the provider; Cardwell's office has assignment forms. The catch is, the applicant, not the provider, must turn in the form. "Providers have learned to be very helpful to victims," Cardwell says. "Social workers in hospitals will sit down and they'll ask the questions and they'll write the information down, and then all the victim has to do is sign it and the social worker puts it in an envelope and mails it. You can do all that as long as the victim signs it."

And then there's another catch: Once the victim has assigned payment to the provider, the provider is prevented from pressing for payment until the Court of Claims has rendered its decision on the victim's eligibility. That can take as long as 16 months. Meanwhile, the AG's office will investigate the victim's application, make a recommendation to the court, and give the assigned provider a copy of the report. Although the AG's report may indicate that the applicant is ineligible for compensation, the provider still must wait for the court's decision before collecting on

Continued on next page

Your Practice Guide

Improvements

Continued from page 18

the bill or sending information to credit-reporting companies.

Change means direct payment

The proposed changes will include direct payment to providers. "The attorney general must rely heavily on these providers when investigating claims to ensure accuracy in the compensation awards victims are seeking," Cook said in his June 23 proponent testimony before the Senate Judiciary Committee. "Some are reluctant to cooperate, knowing they may have to wait months or even years for payment or may have to pursue the victim for reimbursement. Providing direct payment to these providers will build trust, help eliminate fraud, and make it easier for the attorney general's office to investigate claims."

Other changes proposed

Other proposed changes of particular interest to physicians:

- Mental health counseling. The proposal adds reimbursement for mental health counseling needed by a crime victim's immediate family members. The current program reimburses only for counseling referrals for the victim.
- Cost containment. The attorney general's office will be authorized to

evaluate bills according to Bureau of Workers' Compensation guidelines and make reimbursements accordingly.

The Senate will finish hearings on the proposal when it reconvenes in the fall. If the proposal goes through, as Cook expects it will, the changes should go into effect early next year.
—Jan Leibovitz Alloy

Take Action

For more information, contact Lynn Cordwell, Ohio Victims of Crime Program, (800) 824-8263, or Brian Cook, Chief, Crime Victims Services Section, attorney general's office, (800) 582-2877.

September 17, 1999

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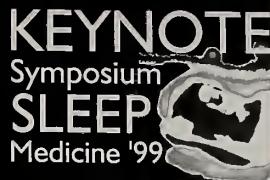
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Your Practice Guide

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"Name and number delivery" service can be blocked

Patients can now choose a calling option that enables them to leave a name and phone number which prompts a call to your office every 30 minutes for up to 12 hours.

The Public Utilities Commission of Ohio (PUCO) and the Ohio Consumers' Counsel (OCC) report that an increasing number of local telephone companies are marketing optional calling features in their service territories. Of specific concern to physicians is the "name and number delivery service" (NND), especially to those physicians who already use a private answering service for their



practices.

This service is activated when a customer makes an outgoing call and there is no answer at the number called. The customer making the call is asked by a recorded announcement after five rings if he or she would like to record a name and number for fu-

ture delivery to the party. If the customer chooses the option, NND records the name and number and rings the called party every 30 minutes for up to 12 hours, until the name and number can be delivered. If the customer does not choose the service, the call will continue to ring, and the calling party is free to hang up or leave a message on the other party's answering service or voice mail, if available. In most areas, NND is activated automatically after the fifth ring, but the customer is charged only after choosing to leave a name and number and only if the name and number is de-

livered. In most areas, the service is automatically on the telephone lines. The charges will appear on the monthly telephone bill, and can be as much as 75 cents per use.

The PUCO and OCC would like to remind customers that they can ask the telephone company to place a block of the pay-per-use calling features that are on your line at no charge, without a service trip to your home or business. If you have questions about pay-per-use services, or how they are billed, contact your local phone company. ■

What must you do when an HMO goes under?

After DayMed HMO went into liquidation March 3, many providers learned the hard way about their own responsibilities toward the company's patients. Will other HMOs liquidate at some point? Probably. Here's what you need to know as a contracting provider:

- You must continue to provide covered services for 30 days from the effective date of the liquidation order, unless the enrolled patient:
 - comes to the end of his or her paid premium;
 - contracts for similar coverage from another health insurer;
 - obtains similar coverage through his or her employer; or
 - ends the contract, either personally or through his or her employer.
- You must provide services to com-

plete medically necessary procedures left uncompleted when the HMO discontinued operations.

- You may not seek compensation or reimbursement from the enrolled patient. You may, however, continue to collect any co-payment required under the patient's coverage. You may also collect fees on a fee-for-service basis for services not covered under the patient's plan. And, of course, you may collect from the HMO or its successor.

Contracted hospitals also must continue to treat the enrolled patient, with the same exceptions, if he or she was receiving inpatient care at the time of the liquidation. However, the HMO may still engage in an appropriate utilization review. — *Jan Leibovitz Alloy*

Take Action

If you have questions about your responsibilities, contact Nancy Gillette, OSMA Division of Legal Affairs, (800) 766-6762, Ext. 6767. Provider responsibilities fall under sections 1751.11 and 1751.13 of the Ohio Revised Code. To find them on the Internet, go to <http://orc.ohio.gov>, and perform a search for Section 1751.

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Your Practice Guide

OSMA material can benefit your practice

The OSMA continues to produce a variety of materials for the benefit of its members.

All of the following items are still available. If you've missed an item and wish to receive it, mark the appropriate space(s) below and mail this form to: *Ohio Medicine*, 3401 Mill Run Rd., Hilliard, OH 43026, or fax to *Ohio Medicine*, (614) 527-6763. Or you can order these materials online by going to the OSMA Web site (www.osma.org) then go to "Membership Information" and click on "OSMA Store".

❑ Pain – The Fifth Vital Sign.

Information on prescribing for patients with chronic benign pain. Offers up to two hours Category I CME. Free to members; \$20 for nonmembers.

❑ Standardized Credentialing Disk.

HMOs are now required to accept a state-developed standard credentialing form. The OSMA has placed this standard form on disk. Free to members; \$25 for nonmembers.

❑ Y2K Readiness Guide

Will your practice be ready when the calendar turns to Jan. 1, 2000? A handbook of steps to take now to prepare, as well as Ohio-specific contacts you can call if you have problems. Free to members.

❑ Osteoporosis information for physicians

This handbook, which launched the OSMA's Women's Health Initiative project, contains Ohio-specific data, as well as more general information. It offers up to two hours Category I CME. Free to members; \$20 for nonmembers.

❑ TrustTalk

OSMA's domestic violence handbook, revised and updated. It offers up to two hours Category I CME.

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❑ DNR rules kit

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Ohio Medicine

A Publication of the Ohio State Medical Association

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Ohio Medicine (ISSN 0892-2451/USPS 407-289)
is published monthly for \$40 a year by the Ohio
State Medical Association, 3401 Mill Run Drive,
Hilliard, Ohio 43026. Periodicals postage paid at
Hilliard, Ohio and at additional mailing offices.
POSTMASTER: Please send address changes to
Ohio Medicine, 3401 Mill Run Drive, Hilliard,
Ohio 43026.

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Colleagues

Newsmakers

H. BRENT BAMBERGER, DO, Centerville, has been elected president of the AAO Hand Surgery Section.

DRS. G. PATRICK ECKLAR, **GEORGE W. BARNETT,** **WILLIAM D. INGLIS,** **WARREN L. WHEELER,** **RALPH D. LACH,** and **MARY MAYER,** Columbus, were recently presented with distinguished educator awards by The Ohio State University College of Medicine and Public Health for their continued support of medical education. The award is presented to physicians in Franklin County and the central Ohio area to recognize their continued sup-

port and involvement with the clinical training of medical students.

SHARON L. EREL, MD, Toledo, was one of seven women honored at the fourth annual "Milestones: A Tribute to Women." Dr. Erel was recognized for her work as the founding medical director of Hospice of Northwest Ohio with the Ohio Pain Management Task Force.

THEODORE D. FRAKER, JR., MD, Toledo, has been selected as governor-elect for the Ohio Chapter of the American College of Cardiology (ACC).

MARILYN J. HUHEEY, MD, Columbus, was appointed to a term ending Oct. 31, 2002, to the State Board of Cosmetology. Dr. Huheey is in the private practice of ophthalmology. She



received her undergraduate degree from Ohio University and her medical degree from the University of Kentucky.

RICHARD A. JOSOF, DO, Toledo, an orthopedic surgeon, has been re-elected as a 1999 corporate board member at Cuyahoga Falls General Hospital.

ROGER J. KRUSE, MD, Toledo, served as director of sports science at the U.S. National Figure Skating Championships in Salt Lake City in February. He was also the lead physician at the World Junior Grand Prix Finals for figure skating in Detroit in March.

MICHAEL L. STARK, DO, Toledo, an ophthalmologist, is medical director of the new Ohio Eye Laser Center, Ltd., located on the Wilson Memorial Hospital campus in Sidney.

Portrait

Akron urologist **Jack Summers, MD,** launches a second career as a novelist and short-story writer.

Growing up in a West Virginia coal-mining camp provided Jack Summers, MD, with a wealth of memories that would lead to a second career. In 1994, he started writing supernatural/horror stories, and within 18 months, had published 12 short stories in genre magazines.

"I've always loved ghost stories," Dr. Summers recalls. "My fondest memories of childhood are sitting in my grandfather's house on a winter evening and listening to my two grandfathers swap ghost stories."

Dr. Summers contracted with a literary agent to publish his first novel, *Caleb*, in 1996. The story centers around a young doctor who is lured to a small town in



Jack L.
Summers, MD

West Virginia by a family of vampires who live in a nearby isolated hollow.

While such genre writing may seem completely out of the realm for a physician, Dr. Summers says his books are actually very well received by his medical peers, noting that more of his physician readers are from outside than within his own local community.

"I think any physician who reads my current novel should like it," states Dr. Summers, referring to his second novel, *The Deadly Practice*. While 90% of the plot is set in Akron, the story revolves around a group of San Francisco malpractice attorneys who begin dying from a disease that resembles the Ebola virus.

With a busy medical practice as both a urologist and sexologist in Akron, Dr. Summers fits his writing time in whenever and wherever he can. He doesn't have any ritualistic writing habits that some more famous writers are known for. "I'm too busy to be that neurotic," quips Dr. Summers.

He does take his writing seriously, though, and advises others interested in

trying their hand at creative writing to do the same. Dr. Summers learned his craft by reading books on writing and, to date, has not taken any formal writing courses. He plans to continue writing, and hasn't ruled out the possibility of one day teaching creative writing.

While Dr. Summers is an avid Stephen King fan, he claims his writing hero is Dean Koontz. "Koontz mixes the strange and supernatural with every day living and makes it almost believable. That's my goal," says Dr. Summers.

His third, upcoming novel blends his medical background with the supernatural. "As part of the creative writing process, I use my medical knowledge and then push it to the 'what if' stage," explains Dr. Summers.

Recently, Dr. Summers donated the author's proceeds from the sale of his most recent book at OSMA's Annual Meeting to the Ohio Medical Political Action Committee. His novels can be found at Borders and Barnes & Noble bookstores, as well as on the Web at Amazon.com. — Pam Willits

Obituaries

DAVID E. BEYNON, MD, Poland, OH, Case Western Reserve University School of Medicine, Cleveland, 1941; age 83; died May 25, 1999.

JOHN G. BOUTSELIS, MD, FACS, Columbus, OH, St. Louis University School of Medicine, St. Louis, 1942; age 78; died April 17, 1999.

KENT L. BROWN, MD, FACS, Westfield, NY, State University of New York at Buffalo School of Medicine, Buffalo, NY, 1942; age 83; died April 30, 1999.

ADRIAN DIAMOND, MD, Cincinnati, University of Cincinnati College of Medicine, Cincinnati, 1940; age 84; died April 30, 1999.

RALPH J. FINTZ, MD, Westlake, OH, Loyola University Stritch School of Medicine, Maywood, ILL, 1941; age 85; died June 7, 1999.

LOUIS J. GASSER, MD, Youngstown, St. Louis University, St. Louis, 1950; age 85; died May 19, 1999.

RAIMUNDS P. LANGINS, MD, Worthington, OH, Latvijas Universiteta Medicinas Fakultate, Riga (Extinct) Latvia; 1943; age 84; died June 20, 1999.

JOHN T. MANTICA, MD, Steubenville, OH, St. Louis University School of Medicine, St. Louis, 1953; age 77; died May 13, 1999.

ROBERT H. MCMASTER, MD, Cincinnati, University of Cincinnati College of Medicine, Cincinnati, 1950; age 82; died May 10, 1999.

WILLIAM M. PORTER, MD, Hillsburg, OH, University of Cincinnati College of Medicine, Cincinnati, 1953; age 69; died April 18, 1999.

EMMETT T. SHEERAN, MD, FACS, Fostoria, Loyola University Stritch School of Medicine, Maywood, ILL, 1947; age 76; died April 24, 1999.

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September 1999

4

Mandatory hospitalists have become a trend in other parts of the country, and, in May the OSMA House voiced its opposition to the idea. Could legislation stop the practice here in Ohio?



6

Retired physicians now have an opportunity to choose emeritus status on the state medical board's biennial registration form.

9

Starting a practice can be a time-consuming chore for the new physician. Simply managing the paperwork necessary to practice can be an effort if you aren't aware of the time factors involved.



16

Managing drug samples requires the same safeguards afforded controlled substance pharmaceuticals. But not all physicians have such protocols in place.



18

If you are audited, it's a good idea to know what your rights are (and you have them) before the inspector arrives at your door.



New company given peer review contract

Ohio's new Medicare peer review organization is a Pennsylvania-based company, KePRO, that's a subsidiary of the Pennsylvania Medical Society.

KePRO, an Ohio-based subsidiary of the Keystone Peer Review Organization, based in Harrisburg, Pennsylvania, replaced Peer Review Systems (PRS), Inc. as Ohio's Medicare peer review organization. KePRO's three-year contract with the Health Care Financing

Administration (HCFA) took effect August 1. PRS will bid on HCFA's Medicaid contract and will continue work on private contracts.

The Keystone Peer Review Organization is a for-profit, fully-owned subsidiary of the Pennsylvania Medical Society. KePRO was formed to pursue the Ohio Medicare PRO contract. It will operate as a separate division of the company, governed by a board of directors composed of

Pennsylvania and Ohio physicians, allopathic and osteopathic; a representative of the Ohio Hospital Association; and a Medicare beneficiary. Its office is located in Cleveland.

The new six-activities contract includes:

- National health-care quality improvement projects;
- Local health-care quality improvement projects;

Continued on page 3

Dr. Abromowitz: Internet prescribing a danger

In testimony before the U.S. House Oversight and Investigations Subcommittee, OSMA Past President Herman I. Abromowitz, MD, presented medicine's concerns over electronic prescribing.

OSMA Past President Herman I. Abromowitz, MD, testified before Congress and on behalf of the American Medical Association (AMA) on the dangers of Internet prescribing. Dr. Abromowitz is a member of the AMA Board of Trustees.



Herman I.
Abromowitz, MD

"The AMA is concerned that some prescription drugs are ordered and dispensed over the Internet in a manner that clearly constitutes dangerous medical practice," says Dr. Abromowitz. "This raises very serious ethical questions and puts patients at great risk. There's an urgent need to establish medical safeguards to restrict these dangerous Internet prescribing practices," Dr. Abromowitz told the House Oversight and

Subcommittee in late J

The AMA recommends:

- A physician should establish or have ready access to a reliable medical history, which generally should include a physical examination of the patient;
- There must be a dialogue between the physician and patient to discuss treatment;
- The physician should inform a patient about a drug's benefits and risks;
- The physician should have appropriate follow-up to assess patient outcome.

"The AMA will continue to develop principles for appropriate use of the Internet in prescribing medications, and will coordinate efforts with other professional organizations," says Dr. Abromowitz.

In the meantime, he adds: "We need to protect and even enhance legitimate electronic prescribing and dispensing practices."



OSMA-supported HB 4 makes news... A news reporter prepares to talk on camera about the benefits of the new Patient Protection Act, House Bill 4, which guarantees an external review process to Ohio patients caught in disagreements with their managed-care plans. OSMA Past Presidents Lonce Talmage, MD (far left of podium) and Su-Po Kang, MD, both from Toledo, await their turn to speak, following a presentation by Gov. Bob Taft.



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Bills, Laws & Rules

National legislative update

Bills focused on antitrust relief, patients' rights, and medical savings account effectiveness all bear watching this fall as legislators head back to Congress.

Several bills moving through the U.S. Congress have the OSMA's attention because of both their impact on the practice of medicine and the potential influence they might have on bills at the state level. With the Congress concluding summer recess, these bills will revive as legislators return to Washington.

Antitrust legislation

The Quality of Health Care Coalition Act of 1999 sponsored by Rep. Tom Campbell (R-California) would provide doctors and other health professionals with an antitrust exemption similar to what unions have in negotiating jointly with health insurers and HMOs. Current federal law prohibits this activity for physicians as an antitrust violation. The so-called "Campbell Bill" is currently pending in the House Judiciary Committee.

What will help the bill move toward acceptance, says Tim Maglione, OSMA director of Legislation, is increasing the number of co-sponsors to the bill. "Of Ohio's 19 congressional representatives, only two to date are signed on. They are Sherrod Brown (D-13th) and Marcy Kaptur (R-19th)," says Maglione. "Ohio physicians should contact members of Congress to encourage them to sign on as co-sponsors." Another good contact would be Steve Chabot (R-1st), who is on the House Judiciary Committee.

This bill is important because it would alleviate many current problems associated with collective negotiations on managed care and unequal bargaining power with HMOs.

Patient protection act

The U.S. Senate is the first branch of the Congress to pass a patient pro-

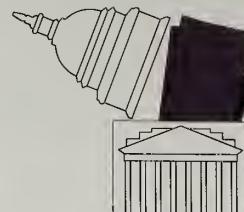
tection measure. But what has occurred is a strictly party-line voting pattern that destroyed a Democrat-sponsored bill and replaced it with a watered-down Republican-sponsored bill. "Unfortunately, Senators Mike DeWine and George Voinovich voted largely along party lines for the Republican Senate package that has a number of flaws," says Maglione. This second version of the legislation would continue to allow insurance companies to impose arbitrary, narrow definitions of what is medically necessary. "Additionally, this Senate-passed version fails to include a right-to-sue provision when patients are harmed by negligent HMOs," Maglione notes.

"We are hopeful that when a compromise proposal comes out of a joint Senate-House conference committee that Senators DeWine and Voinovich will be able to support meaningful patient protection," says Maglione.

In light of President Clinton's threat to veto the Republican-sponsored version of the bill, the House will have to make considerable changes or face the likelihood of the veto. With many House representatives facing voters for re-election, politics as usual may get in the way of this legislation. (For news about a new patients' rights bill, see "Take Action.")

Other bills to watch

Pain relief. The Nickles/Hyde "Pain Relief Promotion Act of 1999" (S 1272 / HR 2260) would add a provision to the Controlled Substances Act (CSA) legitimizing a medical purpose for using controlled substances in pain management, even if use increases the risk of death. Further, any state that authorizes or permits assisted suicide or euthanasia would be "without force and effect" in implementing the CSA. Other provisions of the bill provide training for law enforcement personnel on legitimate use of controlled substances, establishing palliative pro-



tocols for health professionals to follow, and training for health professionals in palliative care.

Financial services act. HR 10 includes provisions for regulating banks but perhaps more important, also addresses the right to confidentiality of communications in a patient-physician relationship and the confidentiality of medical records. The bill is aimed at removing current barriers preventing affiliation among financial institutions. But health insurers are legally considered financial services institutions under the bill. Thus, personally identified information collected by insurers could move to the in-surens' affiliates without permission or patient consent.

Medical savings account effectiveness act. This bill has now been included in the Financial Freedom Act of 1999. It provides for medical savings accounts (MSAs) as a health insurance option that could maximize freedom of choice for patients. — Yvonne H. Barry

Take Action

Check the progress of legislation on the OSMA Web site (www.osma.org) or the AMA Web site (www.ama-assn.org), or call Tim Maglione at the OSMA Department of Legislation, (800) 766-6762, Ext. 6746. The OSMA Web site includes news about the AMA-supported Norwood-Dingell Patients' Rights Bill.

New company

Continued from page 1

- Health-care quality improvement involving Medicare managed care;
- Beneficiary Education and Protection, including case review;
- Special Studies; and
- Payment Error Prevention Program (PEPP).

AMA addresses PEPP

It is this last activity that may be the most controversial. Many physicians are concerned because PEPP, under HCFA's new contract, includes more punitive language than it has had in the past. Specifically, through PEPP, HCFA will now award PROs for catching Medicare payment errors.

When the AMA House of Delegates addressed this issue in June, some delegates went so far as to call the awards "bounties." The AMA House pointed to the need to link quality improvement methods and quality improvement indicators with continuing education. The AMA also has pushed for the creation of a fourth option after the postpayment audit, which would allow doctors to submit additional documentation, retain appeal rights, and refrain from admitting any liability.

In its news release, KePRO states that the PEPP program is "expected to assist hospitals in reducing Medicare payment errors, blending traditional case review with continuous quality improvement approaches. Beneficiary education on Medicare rights will continue, as will mandatory case review of assistants at cataract surgery, hospital notices of non-coverage, hospital-initiated adjustments, external referrals and beneficiary complaints. No special study activities are planned in Ohio at this time."

KePRO is actively recruiting physicians to participate as physician reviewers of the PEPP and mandatory review cases. These physicians will be reimbursed at an hourly rate of \$75 for one year of the contract; \$85 for the second year; and \$95 for the third year.

KePRO is also recruiting physicians to serve in full and part-time capacities. ■

Take Action

If you are interested in any of the offers described above, contact John DiNardi, III, CEO at (800) 222-0771. You may learn more about KePRO by visiting its Web site at www.kepro.org.

Legislation no panacea for hospitalists trend

Mandated hospitalist programs already exist in Florida, Texas and other states. Yet, so far, legislation to prevent the practice has not been successful.

This spring, the OSMA House of Delegates took a stand against the mandatory use of hospitalists (Emergency Resolution 07-99), a practice which more and more insurance companies are using in an effort to lower costs.

Massillon urologist Dan Queener, MD, brought the matter to the attention of the House.

"Since our second residence is in Florida, I was aware of the activity there," says Dr. Queener.

In fact, according to the American College of Physicians-American College of Internal Medicine (ACP-ASIM), Florida is just one of the states where mandatory hospitalist programs have been established. Programs are also under way in Maryland, Missouri and Texas. This trend, disturbing to many physicians, prompted 23 medical societies, including the American Medical Association, to send a joint letter this spring to the American Association of Health Plans and several HMOs, expressing their concern.

Chief among these concerns is a breach of the physician/patient relationship. Unless participation is voluntary by both parties, that relationship suffers, says organized medicine – and Dr. Queener. "My objection to mandatory use of hospitalists is not about the quality of care provided by hospitalists. It's about a choice that should remain with patients and their doctors."

Hospitalists don't wish mandate

It's interesting to note that the National Association of Inpatient Physicians (NAIP), the group which represents the country's hospitalists, is among those organizations that oppose health plans mandating their use. Says Ron Angus, MD, NAIP board member and treasurer and a hospitalist in Presbyterian Hospital in Dallas: "The man-



By working one-on-one with health plans, some physicians have convinced plans not to make hospitalist programs mandatory.

aged-care organizations will find that the prevalence of hospitalist practices will increase rapidly – without their forcing the issue."

Insurance companies, however, claim that they are not forcing the issue, that their programs are *voluntary*. For example, Prudential Insurance Company of America, based in Newark, New Jersey, says their program is not mandated, although it launched hospitalist programs in 18 hospitals this spring. According to an article in *The Wall Street Journal* about Prudential's program: "Prudential officials say they don't consider their program mandatory because it allows primary care physicians to choose whether they want a hospitalist to treat their patients – provided the primary care doctors meet the company's guidelines." The trouble is, a large majority of Prudential's primary care network fails to meet the company's benchmarks, so most feel as though they don't have a choice when it comes to using hospitalists.

Some physicians have been successful in convincing health plans not to make these programs mandatory, says John DuMoulin, ACP-ASIM director

of managed care and regulatory affairs. He reports that his organization has received a commitment from CIGNA to change their mandatory policy to a voluntary one.

Legislation has failed

As it turns out, securing such commitments may be more successful than introducing legislation against the practice, which is called for by the OSMA's resolution: "Resolved, that the OSMA petition the Ohio Legislature to pass legislation prohibiting the mandatory use of hospitalists."

According to OSMA Legislative Director Tim Maglione, the association is researching the extent of mandatory usage of hospitalists within the Ohio insurance market. Additionally, OSMA plans to raise this issue with a patient access task force, created through HB 16, this fall. The OSMA will compile all of this information before introducing a bill in the Legislature.

But other states which have introduced legislation on this subject have not been successful. Legislation against the mandatory use of hospitalists was introduced very late in the Florida State Legislature last session. It was defeated because the bill was never given a hearing, says John Knight, general counsel for the Florida Medical Association (FMA). Florida will try a new tact when the next legislative session begins in March 2000, says FMA Legislative Affairs Director Sandra Mortham. New patient advocacy legislation, which includes language discouraging mandatory use of hospitalists, has been drafted – without even mentioning the term "hospitalist."

In Texas, House Bill 3111, which was introduced in the last legislative session, was short to the point. In addition to defining "hospitalist," it simply stated that a "contract between a health maintenance organization and physician shall not require the mandatory use of a hospitalist."

Alfred D. Gilchrist, legislative director for the Texas Medical Association, said the bill came out of the House Insurance Committee unanimously favored, and without any

opponent testimony. However, while the bill was in the House Calendars Committee, awaiting a date for full floor debate, Humana/PCA and Aetna successfully ran a campaign against it.

According to Tom Banning, director of legislative affairs for the Texas Academy of Family Physicians, even the Texas Association of Health Plans stayed neutral, considering voluntary/mandatory use of hospitalists to be a patient-care issue.

Education may be key

Banning's advice to Ohio physicians and their professional associations is to closely watch the issue developing in other states, and to start building a case against the mandatory use of hospitalists.

"Texas got a late start with legislative education," he says. You should start educating your physicians and your legislators now about what this would mean to physicians and their patients in their own state."

So far, says Banning, Texas physicians have been successful in reversing two attempts at mandatory hospitalist systems – one by CIGNA HealthCare of Texas in Houston on April 1, and one by Humana/PCA in Austin on Nov. 1 – by flooding these plans with letters opposing the practice.

As the OSMA's Dr. Queener points out, "Managed-care systems will push for control of health-care decisions, from a purely economic viewpoint, as far as possible. We cannot rely on them to act in our patients' best interests."

Whether or not the mandatory use of hospitalists will sweep into Ohio is not yet certain, but Dr. Queener urges a vigilant eye. "We cannot allow interference with the physician/patient relationship." – Carol Larimer

Take Action

If you would like to help educate legislators about the need to oppose a mandatory hospitalist system, contact the OSMA Department of Legislation (800) 766-6762, Ext. 6742.

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Med board creates emeritus status

Registration as an emeritus is not a licensure, although a physician may continue to refer to himself or herself as "doctor."

The State Medical Board of Ohio has created an emeritus registration for retiring Ohio physicians. According to the rules adopted July 1, a practitioner may either indicate a request for emeritus status on the biennial registration form or petition the medical board. To qualify, a physician must:

- be licensed to practice in Ohio for at least 10 years;
- declare that he or she is retired from active practice in all jurisdictions; and
- not have had his or her license limited or revoked by a disciplinary action of the medical board.

Registration as an emeritus is not a licensure. Although an emeritus physician may refer to himself or herself as "doctor," the physician may not practice medicine. The emeritus registrant is not obligated to maintain CME requirements, or to pay a renewal fee. An emeritus physician who chooses to return to active status must complete CME requirements for the time he or

Medical Board Report

she was inactive. A physician who has been registered as an emeritus for at least two years may change status with approval from the medical board and an application for restoration. The physician must also pass an examination which may be written, oral or both. The medical board may require additional training.

The board may, as a disciplinary action, refuse to issue emeritus status or cancel it. Although such action cannot be appealed, it is not reportable as a disciplinary action to the federal national practitioner data bank. — *Jan Leibovitz Alroy*

Weight reduction drug guidelines

The medical board's rule for using controlled substances for weight reduction is fully explained in the summer issue of *Your Report*, the board's quarterly newsletter.

Your Report is also available on the board's Web site ([link to it from the OSMA Web site, www.osma.org](http://www.osma.org)). Included in these guidelines: general requirements for prescribing; short-term treatment; maintenance treatment; and restarting treatment.

The rule does not apply to Schedule II controlled substances, over-the-counter drugs, or prescription drugs which are not listed as controlled substances. The present rule was scheduled by the board to be re-visited in July, with input from physicians.

Also in this issue of *Your Report*, you will find the board's position paper on:

- delegation of medical tasks;
- activities during license suspension;
- reimbursement documents; and
- release of spectacle prescriptions.

"The ABCs of Reporting Infectious Diseases" is another article worth reading and saving.

Recorded phone calls

Recording equipment has been added to medical board phones to monitor calls coming in to the Licensure and Public Inquiries departments. Callers will be informed they are speaking on

a recorded line. Board Executive Director Ray Bungarner said he believes this may help lower the level of tension on many of these calls.

Pain committee named

Five members have been named to the board's Ad Hoc Pain Advisory Committee: Jeffrey A. Brown, MD, professor of neurosurgery, Medical College of Ohio at Toledo; Anthony D. Chila, DO, family practice professor, Ohio University College of Osteopathic Medicine; Vincent T. Martin, MD, internal medicine, University of Cincinnati; Michael Stanton-Hicks, MD, director of pain program and anesthesia, Cleveland Clinic; and Thomas Greter, MD, Cleveland, chair. ■

Take Action

If you would like a copy of the board's guidelines on Using Controlled Substances for Weight Reduction, as it appeared in the Summer 1999 issue of *Your Report*, contact the *Ohio Medicine* reader response line, (800) 766-6762, Ext. 6580, and ask for item #21-99.

Medicine's friends

Rep. Randy Gardner: Sponsor of Ohio's HB 4

Rep. Randy Gardner (R-Bowling Green), Speaker Pro Tem of the Ohio House of Representatives, sponsored House Bill 4, the Patient Protection Act that was signed into law by Gov. Bob Taft this summer. The bill guarantees patients a right to appeal disagreements with health-care plans to an independent, external review panel. The OSMA supported this bill throughout its passage. Here's a closer look at the man responsible for introducing this important legislation.

Why become involved in an issue as potentially controversial as House Bill 4?

Rep. Gardner: My life in the last five or six years has pointed out the need for changes in the managed-care

system. I've seen how managed care works and doesn't work. I think it's important to point out, however, that patient protection, as provided in House Bill 4, isn't necessarily against managed care. As with any reform bill, it seeks to make changes without dismantling the entire managed-care system.

In reforming managed care, I consider cost containment a secondary goal after developing a greater sense of involvement and input from both patients and physicians. The bottom line, I think, is to restore confidence in managed care.



Rep. Randy Gardner

Has any personal involvement with managed care influenced you?

Rep. Gardner: I suppose indirectly. Because of where I live, there is only one physician who I am authorized to see, according to my state HMO. A bureaucratic issue prevented me from going to see the physician at a time I needed to. It drove home, for me, a very common complaint from constituents about access to care.

Then, I encountered a physician who complained to an HMO when a patient was denied surgery for her cancer. Shortly after, the doctor was dropped entirely from the plan. I had to wonder if this was a coincidence or not.

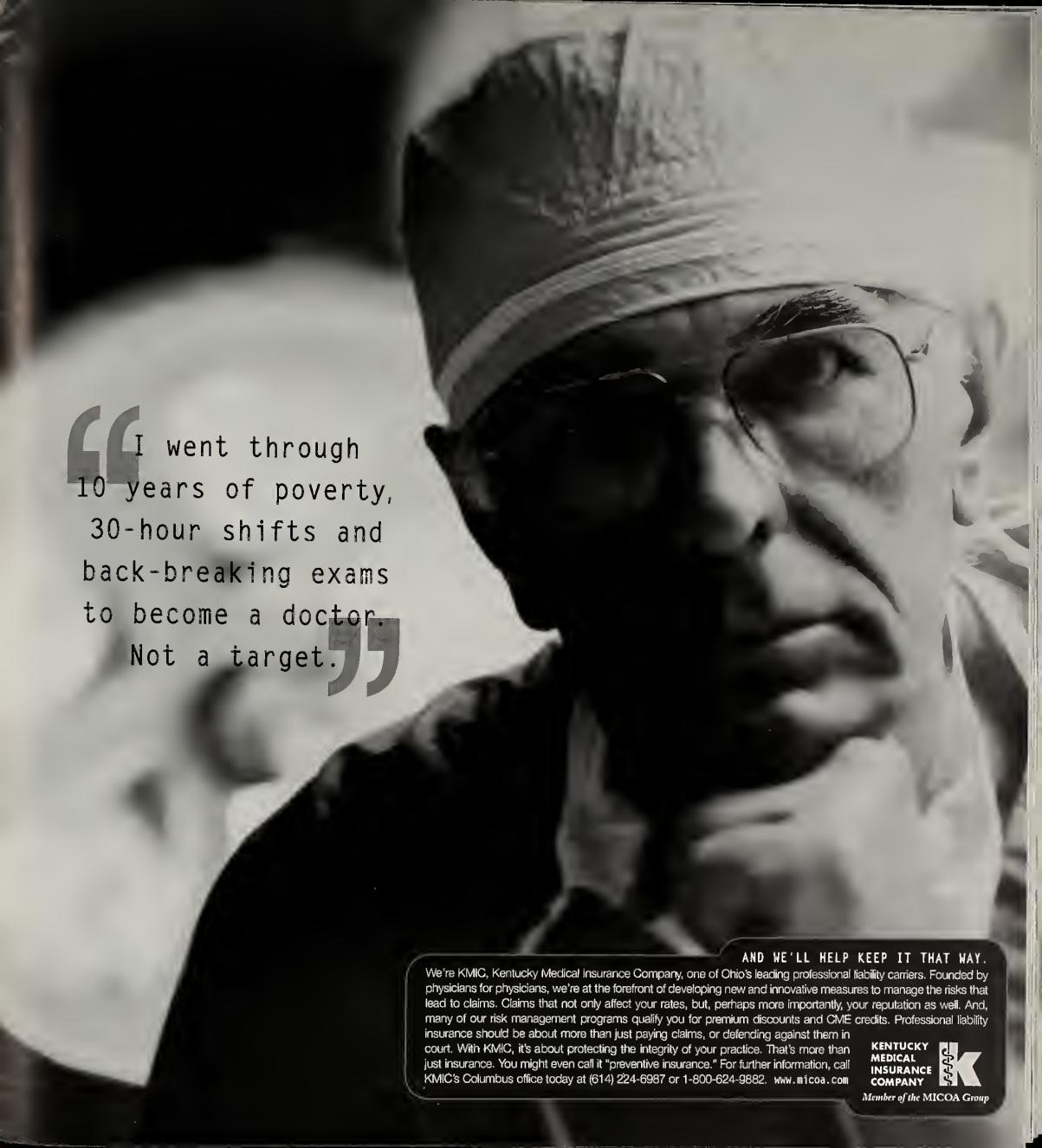
These two experiences led me to want to help the governor when he made health-care reform a top priority, so I

was pleased to become involved with House Bill 4. The pendulum has swung a couple of times in the last decade regarding health-care decision making. I found House Bill 4 interesting because I believe both patients and physicians need additional rights in the health-care decision-making process.

I have a good and longstanding relationship with the OSMA. The strong trust we have developed has been productive, and I felt that, with the OSMA's support, we would be able to achieve the protections provided in HB 4.

Wasn't House Bill 121, the asthma inhaler bill which recently became law, a result of listening to one of your constituents — a physician?

Continued on page 8



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Rep. Randy Gardner:

Continued from page 6

Rep. Gardner: Yes, that's right. Wayne Bell, MD, of Bowling Green mentioned to me at a pancake breakfast I was attending in my district, that asthma inhalers can't be carried by students in school. They fall under restrictions that prohibit students from carrying any medications in school buildings. But, as Dr. Bell pointed out to me, the problem comes when a student needs the inhaler in short order, and must report to the nurse's office, or in some smaller schools, to the main office, to retrieve it. The amount of time needed to get the inhaler can be critical, and the fact that it is so inaccessible to these students presents real problems.

I talked with the Ohio State School Board Association and with U.S. Rep. Mike DeWine, who has asthmatic children in his own family. Shortly after that, the legislation was crafted and introduced. It passed the Legislature several months ago, and this school year students will be permitted to carry their own inhalers.

How else can physicians become politically involved?

Rep. Gardner: I hope that most physicians call their legislators at home, write them a letter, meet them at their hospitals, their offices, wherever, to discuss health care's most pressing issues. Legislators don't inherently have a lot of background on medical issues, and physicians are seen as the experts who can provide the input we need.

In my own experience, in my first year in office, the Wood County Medical Society invited me to a meeting as a speaker. But mostly I listened. In this era of term limits, professionals, like physicians, become more important to provide background information to legislators. —
Yvonne S. Burry

Take Action

The OSMA Legislative Department can help physicians set up appointments with their Ohio representatives and senators. For further information, call Krista Bistline at (800) 766-6762, Ext. 6748.

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Indepth Report

Young physicians

Starting practice is a job in itself

You finally have those initials behind your name, and you're itching to practice medicine. You've waited an awfully long time—and you have another wait ahead of you. Licensing can take months. And then there's your Medicare credentialing. And your DEA number. And your Medicaid registration. And so on and so on.

OSMA's Department of Ombudsman Services has an information packet, including forms, to get you started. Ask for "New Practice Information." (See "Take Action") Here are the basics:

State licensure... 8-10 weeks

Once you file for licensure, you'll wait at least eight to 10 weeks while the Ohio State Medical Board considers your application. If you're coming to Ohio from out of state, you might wait even longer, because many states don't have reciprocal licensure with Ohio and much of the information the medical board needs will have to come through a national databank. The rest of the process hinges on licensure.

"That's the first step," says Bill Fry, director of Ombudsman Services. "You have to have your license before you can apply to Medicare or Medicaid or most of the commercial carriers. They will not take you without evidence of licensure."

Medicare certification... 8-10 weeks (if the form is completed correctly)

Many insurance carriers require that you obtain a Medicare PIN number before they'll take an application from you. That takes another eight to 10 weeks, assuming you only need to fill out Medicare's Form 855 once. "You better fill it out right," Fry says, "because if you don't, eight weeks can go by, it can be sent back to you, and you have to start all over again. There are gross instructions on the 855 form that



OSMA provides "New Practice Information" booklet.

most people don't bother to read, because they're about three pages. But if you do it wrong? I've seen long delays in getting a Medicare number because it's incorrectly completed." And occasionally there are delays just because there are delays. "I assisted one new doctor who was in solo practice," Fry says, "who had to get a second mortgage on his home to get money just to be able to operate. He could see the patients but couldn't file a claim until the Medicare number was issued." The Medicare process has improved over the past few years, Fry says, and generally when there's a problem it's because the 855 form is incomplete.

Medicaid... Negligible

This is less a certification than a registration process. "They don't actually credential," Fry says. "They know Medicare's credentialing and they know the state board has credentialled, so Medicaid is not generally as difficult. There's not a lot of paperwork."

Managed care... Depends

"Here's where it really gets sticky."

For your Medicare provider number

There are four ways to obtain an application for a provider number:

- 1.) Fax to: (614) 277-6805.
- 2.) Access Web Site: www.nationwide-medicare.com.
- 3.) Call Provider Call Center: (614) 277-1199.
- 4.) Written request:
Nationwide/Medicare, P.O. Box 182195, Columbus, OH 43218.

Here are a few hints and tips to make the process easier:

- Information must be on the appropriately colored application (there are exceptions to certain sheets and attachments.)
- The forms are not to be copied.
- All signatures must be original (no stamps, faxes, etc.)
- Be careful in the use of "N/A" (Not Applicable).
- Read instructions carefully!
- Answer every required question.
- Assign the project to a qualified person familiar with the business/organization and who is in a position to gather the required information.
- The hotline number for questions concerning completing the form is (614) 277-6181. This number is not to be used to check status or if Medicare has received the form.

(The above material has been excerpted from the OSMA handbook "New Practice Information." For a copy, see "Take Action" below.)

ferent agencies. Wouldn't it be helpful if it were all centralized, where you'd go out and get credentialled one time?"

—Jan Leibovitz, Alloy

Take Action

For more information, contact Bill Fry, OSMA director of Ombudsman Services, (800) 766-6762. If you would like a copy of the "New Practice Information" booklet, produced by OSMA Department of Ombudsman Services, contact the Ohio Medicine reader response line, (800) 766-6762, Ext. 6580, and ask for item #23-99.



Letters

Alternative Medicine still requires skepticism

To the Editor:

I am responding to *Ohio Medicine's* July In-depth Report on Alternative Medicine, both as a physician and as past president of Central Ohioans for Rational Inquiry (CORD). This organization is part of a national network of organizations devoted to the examination of unusual claims, and to educating the public about the logic of science.

I am certainly in agreement with the article's underlying implication that professionally well-educated physicians should be knowledgeable and open-minded about "Alternative Medicine" (AM). Many of our modern medicines have had their genesis in herbal remedies, and more than a few medical heretics have later been proved correct. Even AM's nemeses, the multinational pharmaceutical conglomerates, recognize this as they systematically analyze nontraditional plant and animal compounds for useful biological activity. The reality, however, is that AM, free of peer and regulatory scrutiny, has often provided a haven for those who are unknowledgeable, unethical or opportunistic.

A variety of reasonably unbiased print and online resources are available to physicians seeking information on AM remedies. These range from the lay-oriented such as *Consumer Reports*, to the general medical, as Unproven Remedies in the American Cancer Society's monthly *CA*, to peer-reviewed journals like *Scientific Review of Alternative Medicine*.

Michael S. Lehv, MD, JD
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OSMA News



Legislative victories for Ohio physicians

As legislators head back to Columbus this fall, it's a good time to reflect on what the OSMA has already accomplished this year, legislatively speaking.



Dr. Ulof

So far, we have scored victory after victory at the Statehouse. Leading the way is the **Patient Protection Act**, House Bill 4, signed into law by Gov. Taft this summer. I've written on this subject before, so I'll simply repeat this bill may be one of the best pieces of legislation our patients have seen in a while. The new law guarantees them a right to an external review process by an independent panel of experts when they wish to appeal a decision made by their health plan. The OSMA initiated the bill as a second step toward managed-care reform (our Physician-Health Plan Partnership Act was the first). We're pleased that state legislators also saw the need for this legislation.

Other victories this year include:

- **The passage of House Bill 16**, another OSMA-initiated measure that calls for a task force to examine the issue of patient access to preferred provider plans, point-of-service plans, and other open panel plans for health-care coverage.
- **Increased reimbursement for Medicaid providers**. The OSMA put time and effort into placing in the state budget bill a provision that increases, for the first time in many years, the Medicaid reimbursement rate.
- **Defeat of House Bill 200**. This legislation would have repealed the requirement that children entering kindergarten be immunized against hepatitis B.
- **The passage of House Bill 71**, the duty-to-warn bill, that creates a statutory duty for mental health professionals to warn others of the potentially violent acts of their patients. The advantage, here, is that if a mental health professional

President's Perspectives

follows guidelines established in the bill, he or she will receive immunity from liability if that patient harms a third party.

Of course, there is more work to be done as the Legislature resumes its activities this fall. For example, we continue to follow:

- **The APN bill**. The OSMA has already been successful in some respects, with regard to House Bill 241. Before the bill left the House this summer, the OSMA was able to: establish an APN-to-physician ratio in the bill (prior to the OSMA's efforts, there were no ratios, oversight, or any kind of quality assurance requirement); assure physician input; limit the drugs to be prescribed; and removed proposed expanded scopes of practice for nurse-midwives. We'll continue to follow

this bill as it makes its way through the Senate, attending to such issues as: returning the physician-to-nurse ratio to 2:1 (it's now 3:1); requiring prescribing nurses to be employed by their collaborating physicians; whether to grandfather in APNs without master's degrees; and how to structure a fellowship program that will be required of all APNs prior to their obtaining a prescribing certificate.

- **The trauma bill**. This bill had been assigned to a Senate subcommittee over the summer. As the Legislature resumes, we will follow this bill closely to make certain it stands a good chance of passing. The OSMA supports this bill, and has worked hard to bring the bill this far.

Survey after survey indicates that advocacy, both at the Statehouse and our nation's capital, is one of the reasons you join organized medicine. Certainly, it's one of organized medicine's greatest strengths. I just thought you should know that your dues dollars are being well spent. ■

Are you Y2K compliant?

If you are still uncertain as to how to prepare your practice for any potential Y2K failures, the OSMA can help.

The OSMA's *Y2K Readiness Guide* provides you with state-specific information that helps you: Identify problem areas; determine what to do (who to contact, etc.); test your systems; implement changes and updates; and draw up a contingency plan. For a copy of the *Y2K Readiness Guide*, contact the *Ohio Medicine* reader response line, (800) 766-6762, Ext. 6580, and ask for Item #12-99. If you have Y2K questions, contact Todd Baker, OSMA Division of Public Affairs, (800) 766-6762, Ext. 6734.



Four months to go and the Y2K Conversion is 1/50th of the way there.

OSMA happenings...

OSMA moves to focused task forces...OSMA President David J. Utkak, MD, is in the process of establishing focused task forces (FTFs) to replace most of OSMA's current committees. The concept for this major structural change grew from the OSMA Task Force 2000 report, published November 1997, and adopted by the House of Delegates in May 1998. As described in that report, FTFs will propose policy, analyze issues, and take action to accomplish the goals for their area of responsibility. They are empowered, as well, to establish ad hoc working groups - which may be composed of nonmember and/or nonphysician experts - to help them work toward task force goals. Letters will be sent to determine member interest in serving on these task forces. If you have not received information, but would like to serve on a task force, contact the *Ohio Medicine* reader response line. The letter will be sent to you. Call (800) 766-6762, Ext. 6580 and ask for Item #24-99. For more information about the change from committees to task forces, see the president's column in the October 1998 issue of *Ohio Medicine*.

Interested in an e-mail newsletter?...If you're looking for up-to-the-minute news on important health-care issues, e-mail your interest (along with your address) to Karen Kirk, OSMA Division of Public Affairs at kkirk@osma.org. She is collecting input from physicians who might like to receive a weekly electronic update.

OSMA quizzes group managers about needs...The OSMA held a focus group interview last month with group practice managers in an effort to refine the practice management support services currently provided by the association. The half-day task force focused on what OSMA services the managers find useful, and how the OSMA can better communicate these services to group practice managers. This input will be used to improve the level of service offered by the association. ■

On the Web...

Educational opportunities

The former Continuing Medical Education section on the OSMA Web site is new and improved. Now you can find any and all information having to do with educational materials, seminars, applications on becoming an accredited sponsor and/or planning a CME activity in the Educational Services section of the Web site.

The new name – Educational Services – reflects the change in the name of the OSMA department (the Department of Continuing Medical Education and Outcomes Research changed its name earlier this year) whose responsibility is to develop CME activities.

The OSMA has always believed that patient care and patient outcomes are enhanced by study and learning throughout the professional life of every physician, that's why the OSMA develops continuing medical education courses for physicians.

By going to the "Educational Services" section, members can find a complete list of CME being offered by the OSMA and other entities throughout the state. A new feature allows members to register online with a credit card for any OSMA-sponsored seminar or activity. Those physicians or staff members interested in "Meeting Management Education" can find a list of those programs, and have an opportunity to register online for those as well.

The OSMA assists members in locating quality educational services at the local level by maintaining and providing statewide listing of CME opportunities. The following opportunities can be selected by date, location, topic or sponsor. Unfortunately, members cannot register online for these meetings, however the listing will contain pertinent information, date, time, place, plus a contact name and phone number to register on your own.

As a public service, the OSMA now provides limited information to patients on selected topics of interest in the "Patient Education" section. You can direct your patients to the Patient Education section or print out information to distribute to them. This section will include information from the two-year OSMA-sponsored Women's Health Initiative.

continued on page 14

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AMA Report

PSA group is your advocate in the marketplace

By Herman I. Abramowitz, MD

Experiencing problems with a managed-care plan or contract? If so, the AMA's Private Sector Advocacy group wants to know about it...and to help.

From time to time, all of us experience problems with today's managed-care marketplace. Some of these problems, however, are more pressing than others. Maybe we see language or a provision in a health-care contract that seems to threaten our autonomy, something that prevents us from taking the best care of our patients. Or we are made aware of a practice that seems to compromise the quality of care in favor of a managed-care plan's bottom line.

When you arrive at these situations, there are two things you can do. The first

is to report such actions or provisions to the OSMA, through its Department of Ombudsman Services. The

OSMA will monitor the situation on the local level. The second thing to do is to contact the AMA's Private Sector Advocacy (PSA) group. This group of AMA staff members is always ready to advocate on your behalf against egregious managed-care

practices that are taking place in today's market. But first, they have to hear from you. They need *your* input regarding the

dynamics of your local health-care marketplace. In fact, this information is so

essential to their work that they have established two ways to contact them.

If you need instant access to the group, call the PSA telephone hot line, (800) 262-3211. This toll free number will provide you with access during the normal

business hours of the AMA. That's 9:30 a.m. to 5:45 p.m. for those of us here in Ohio. An AMA representative will

receive your call and refer you to the PSA staff member with the relevant expertise on your private sector issue. Outside of these hours, an external call center will receive your call and forward your message to the PSA staff.

You may also contact this group through the PSA's interactive Web page www.ama-assn.org/advocacy/psadvocacy/index.htm. (You can access the AMA's Web site through our own Web site, www.osma.org, and link from there.) The PSA Web page will give you a basic understanding of the group's mission and the services available to address your issues. The page will also update you on the group's current campaigns, and includes as well a market trends publication that identifies health-care issues that will have an impact on physicians of all practice modes.

Continued on page 14

From the county files ...

Toledo Academy wants women physicians to "walk the walk"

Your lifestyle presents the best role model for patients. A program designed for "Women in Medicine" month will help women physicians practice what they preach.

You probably urge your more moderate patients toward daily exercise and better nutritional habits; but do you walk the walk? That's the challenge Tonda Hollenback, health educator and exercise specialist, will present to women physicians on Sept. 20.

As part of AMA Women in Medicine Month (September), the Academy of Medicine of Toledo and Lucas County has scheduled Hollenback to present "Take a 30-Minute Walk and Call Me in the Morning...A Prescription for a Healthy Lifestyle."

The 6 p.m. "come as you are from the office/hospital" program for women physicians will include a "fast food" dinner featuring examples of healthy food that can be easily prepared or heated at work.

Easy Pasta 'Pizza'

(makes 6-8 servings)

Ingredients:

- 16 oz. angel hair pasta
- 1 egg or 2 egg whites
- 2 c. shredded part-skim Mozzarella cheese
- non-fat cooking spray
- optional: pizza sauce

Instructions:

1. Pre-heat oven to 350 degrees.
2. Cook pasta as directed on package; drain but don't rinse; place in mixing bowl.
3. Stir in egg (which will scramble in the hot pasta) and 1-3/4 c. of the cheese.
4. Coat the inside of a glass 9" cake or pie pan with nonfat cooking spray.
5. Pour the pasta, egg & cheese mixture into the pan; shake to distribute evenly; top with remaining cheese.
6. Bake at 350 degrees for 20 minutes or until top turns golden brown; while pasta pizza is cooking, prepare or heat your favorite sauce.
7. Cut "pizza" into any size wedges or chunks; serve hot with or without dipping sauce.
8. Refrigerate unused portion; re-heats well in microwave or oven; also good cold.

(See above for an easy make-ahead recipe.) "The idea is to include more than one food group - and we don't include 'fat' as a food group - in one-dish meal," Hollenback says.

She'll also be sharing easy, workplace physical activities that require simple, inexpensive equipment, such as a chair, an exercise band or exercise balls.

"Physicians know the quality-of-life benefits of exercise," says Hollenback, "but often time factors prevent working out. This is a reminder that regular, moderate exercise for 30 minutes most days of the week, even broken up into three shorter sessions each day, will reap some cardiovascular, strength and flexibility benefits."

According to Mary Croak, Academy director of communications, "We hope that physicians who practice what they already know as a healthy lifestyle will positively influence their colleagues and staffs, and be more likely to promote these simple activities to their patients. Tonda will also share examples of how to make your practice waiting area a health-promotion center." — Carol Larimer

Take Action

"From the county files..." is designed to show how county medical societies are identifying and responding to issues in their area with programs and activities that you may wish to borrow for your county. If you would like more information about this particular program, or are interested in registering for "...A Prescription for a Healthy Lifestyle," contact the Academy of Medicine of Toledo and Lucas County, (419) 473-3200.

On the Web...

Continued from page 12

tative — osteoporosis, domestic violence, pain management and breast cancer. A current list of OSMA Accredited Sponsors of CME is also available here. National trends indicate that physicians are most interested in practice-based, patient-related educational services. CME activities developed by institutions in the local community can effectively assist in fulfilling these needs.

The OSMA is accredited by the Accreditation Council for Continuing Medical Education and is the only accrediting body in the state of Ohio with authority to accredit institutions/organizations to sponsor CME for physicians. Those institutions interested, can click on "How to become an accredited sponsor" and get all the information.

The OSMA is available to work with group practices, organizations and other

entities in planning formally structured educational activities for CME credit.

Under "Planning a formally structured educational activity" you'll find a brief overview, pre-application and agreement form that must be completed and returned to the OSMA. ■

Take Action

If you have any questions with the new Educational Services section of the Web site, please contact Karen Kirk at kkirk@smo.org or call her at (800) 766-6762, Ext. 6754.

GENERAL PHYSICIAN

Massillon Psychiatric Center, a 161-bed JCAHO accredited behavioral healthcare organization, is seeking a general physician with a current valid Ohio license to provide general medical care to psychiatric inpatients. This is a full-time Civil Service position with additional compensation for required on-call responsibilities. State benefits include: malpractice insurance, personal/sick/educational leave, health/vision/dental/life insurance, and a retirement plan. Massillon Psychiatric Center is an EEO/ADA employer committed to excellence through diversity.

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How to increase your political involvement

Medicine needs a strong voice, both at the Statehouse and at the Capitol. That means more grass-roots support from people like you. To improve your advocacy skills, make plans to attend the 1999 AMA Grassroots Conference, Sept. 22-23 in Washington, D.C. In addition to sharpening your grassroots political

skills, you'll be briefed on legislative, regulatory and political issues that are vital to your practice, and to your patients. To register, visit the AMA's Web site, www.ama-assn.org/political education and register online, or call the AMA Customer Service Center, (800) 621-8335. ■

AMA Report

Continued from page 13

PSA activity generated a great deal of interest at the AMA's Annual Meeting this past June. I think it's important for you to know that the AMA does want to help you when you come across a managed-care injustice, and it has the means to do so. Get in touch with the PSA group and let them know what is

going on in your area. The profession, and our patients, will be better off as a result of your input. ■

Herman I. Abramowitz, MD, Dayton, is a member of the AMA's Board of Trustees.

From HOME REMEDIES To HMOs



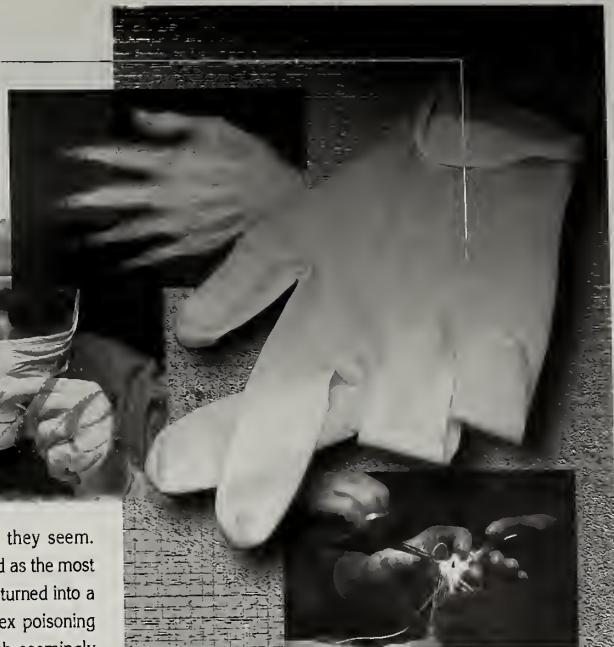
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Protection or Poison?



Things are not always as innocent as they seem. What physicians and surgeons once trusted as the most basic of safety precautions has frequently turned into a life-altering threat. Victims of Type I Latex poisoning daily face dangerous exposure from such seemingly harmless sources as a child's toy balloon. This can result in devastating career and lifestyle changes—and in some instances, even death!

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Practice Tips

Managing drug samples

Because of the safeguards needed for handling controlled substance pharmaceuticals or the specific requirements for handling potentially toxic or carcinogenic substances used to treat cancer, some practices simply do not use samples at all. But more often, samples of the more common drugs are acquired, often in substantial quantity. They provide medication for patients with limited insurance or ability to pay; they also provide an easy way to test a drug's action before using it for extended treatment of a disease or condition.

When the Ohio Board of Pharmacy (BOP) issued new rules for dispensing and providing instructions for samples on June 1 (see *Ohio Medicine* May 1999 issue), the key points centered around proper labeling, including product information with the drugs, and additional labeling by the dispensing physician when recommending a specifically different or "off-label" use or dose. While most physician offices have at least an informal protocol in place for managing pharmaceutical samples, others do not.

Three issues come into play in managing drug samples: acquiring samples, keeping track of the samples, and protecting the samples from unauthorized access.

Acquiring drug samples

William T. Winsley, RPh, director of the BOP, says, "The bottom line is federal law. A physician can request drug samples, but the drug company cannot come in and dump them in the sample closet." One immediate and potential source of problems can be in a practice or clinic with numerous physicians, any of whom could accept the offer of samples, and all of whom might dispense them. Add to the equation the possibility of a staff member stealing samples and trading them for other drugs, and the situation can escalate to the level of real trouble.

Of course, the teeth of the applicable federal regulations are designed to deter trafficking in dangerous drug samples, including controlled substances. But especially in response to a complaint or an au-



dit, the same potential punishment could apply to common samples that have been mismanaged or inadequately tracked — namely imprisonment for up to 10 years or a fine up to \$250,000, or both.

Winsley offers an overarching rule: "To make life simple, keep control of the situation."

Keeping track of samples

There are three parts to managing the flow of samples through a practice: receiving, dispensing, and disposing.

Whether drug samples enter the office via an enthusiastic sales representative or via package delivery, the first step is an inventory. "If you signed for 100, make sure you get 100," says Winsley. Samples often have a lot of packaging and propaganda, but according to Ohio law, office staff may not "shuck" the samples to retrieve the few doses and accompanying reference/dosage sheet from each sample unit. "We suggest a simple log with a separate sheet for each medication. It should include dates and amount received on receipt. It should also include the date, patient name, amount, and initials when samples are dispensed." Samples further need to be noted on the patient's chart or treatment record.

While a physician can dispatch a nurse or other authorized staff member to get samples, log them out, chart them, and organize them for a patient, the physician must directly dispense the sample to the patient and sign it out. "Remember that the patient can't be charged and cannot receive repackaged drugs," says William Schmidt, the Medical Board of Ohio's assistant executive director. "Keep both separate log sheets and notations in the patient's records."



Sensible sample management

The Orthopedic Multispecialty Network, Inc. (OMNI Orthopedics) in Beldon Village, Canton, and the Alliance Physicians group in Kettering/Dayton suggest these sensible management techniques for drug samples:

- Only one centralized, locked storage area for the entire practice.
- The physicians agree on what medications to carry in the sample room; usually it's limited to the top two offerings in any product line.
- Each physician has one clinical person (medical assistant or nurse) who participates in patient visits and acts as the liaison when samples are dispensed.
- The clinical person has a key to the sample room, logs out the samples, gives them to the physician, who in turn gives them to the patient and makes a note in the patient's chart.
- In/out inventory of the sample room is done monthly; outdated samples are pulled and disposed of in appropriate ways; stock is rotated so that closest-to-outdated materials are first to be used.
- Only one person is authorized to order samples.
- One person counts and inventories samples when they arrive.
- Write expiration dates on samples and use color-coded labels (one for each month).
- Keep all signed receipts for drug samples in a folder for at least three years.
- Assign a "lot number" to each shipment of drug samples; log it.

Protecting the samples

Cabinet or sample room access must be limited to authorized personnel only. Winsley says this does not include sales representatives, unless they are supervised. It is the physician's legal responsibility to prevent unauthorized access by anyone, including the cleaning team that visits after office hours. "Too often," says Winsley, "the key to the sample closet or room is kept in the center drawer of the desk nearest that area." Even for noncontrolled drugs, the sheer volume of samples heightens the possibility that some could disappear, and this could be a legal liability. Volume can be controlled by keeping close tabs on the drug representatives and communicating with them the actual need and use patterns within the practice.

"Historically, there has been the attitude that because it's a sample and not a controlled substance, it's OK for the secretary to take some home," says Schmidt. "Not true," he notes. "Documents need to account for every pill, every drop; treat them like controlled substances with receipts, logs, etc. Office help can't take them, even with permission." He adds, "They are still serious drugs and a physician needs to make sure no one gets to them."

Disposing of the samples

Winsley says that the outdated or otherwise unwanted samples must be tracked, too. A log sheet, while not required by law, could indicate when, how and why samples were disposed of. Conventional drugs can be flushed down a toilet or dissolved in water and poured down a drain. Toxic substances, like anti-cancer drugs, have special rules that usually involve contracting with a licensed disposal company. Controlled substances likewise have specific regulations and authorized disposal vendors. Such companies must be licensed with the BOP and/or U.S. Drug Enforcement Agency (DEA).

For hospital-based practices, of course,

the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has protocols and its own inspectors. Pharmacies may not possess samples. Independent practices are subject to BOP regulations and are subject to audit by the BOP. — Yvonne H. Burry

Take Action

For complete legal language pertaining to drug samples, the BOP provides *Current Laws & Rules*; visit their Web site at www.state.oh.us/pharmacy/sh99all.pdf, or link to it from OSMA's Web site, www.osmo.org.

Third-party update

More Medicare HMOs pull out...
Seven more Medicare-plus Choice insurers plan to discontinue service in 29 Ohio counties next year, which could leave some of your senior patients without health-care coverage in 2000. QualChoice, Family Care, Aetna, PacifiCare, Summa, Cigna, and Community Health Plan will be dropping service in some (but not all) Ohio counties. The HMOs must provide 60 days notice of when they're pulling out, and are required to give options in those areas. For more information about which counties will be affected, contact the Ohio Senior Health Insurance Information Program, (800) 686-1578.

University Medical Services calls it quits with Aetna...University Medical Services Association (UMSA), greater Dayton's largest multispecialty medical group, has terminated its provider contract with Aetna U.S. Healthcare. The group outlined several problems experienced over the last 18 months: Aetna's "all-or-nothing" contract; an unwillingness to incorporate provisions that UMSA felt would create a more workable contract; and Aetna's refusal to pay for services rendered by UMSA's newly-employed physicians, because UMSA had not signed the Aetna contract as presented. UMSA is one of many groups nationally and the second locally to sever its relationship with Aetna.

United Healthcare initiating polypharmacy intervention program...
Members of United Healthcare's Medicare Complete have been invited to participate in Medicare Review for Healthy Living, a national polypharmacy intervention program that will target the 15%-20% of seniors who take five or more maintenance medications. Under the program, clinical pharmacists will evaluate the medication histories and contact members who may have potential problems with drug interaction or medication doses. Physician input will be sought on contraindications, drug-drug interactions and excessive doses. Also, the pharmacist will obtain the member's consent to clarify some issues with his or her physician.

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Your Practice Guide

Know your rights in case of an audit

The inspector waiting outside your office may seem intimidating, but you do have rights during office audits. Here's how to proceed if an inspector knocks on your practice door.

Most government audits are announced with a letter from the Office of the Inspector General or a Medicaid fraud unit that says an inspector would like to visit your office on such-and-such a day to look through your records. Managed-care companies also can audit you, but exactly how they announce themselves is governed by the contracts you sign with them. If your contract allows the company to request an immediate audit, you may open your office door one day to find an investigator there, sleeves rolled to the elbows, ready to leap into your records. More often, though, a contract will specify "reasonable prior written notice," says Margit H. Nahra, JD, a partner with Michaels & Bonner in Washington, D.C., who specializes in defending

health-care fraud and abuse investigations. In that case, without that notice, you can refuse the investigator immediate entry.

No matter how the notice arrives, an audit is a daunting prospect. Here are some survival tips:

Call your attorney. "I'll call the agent," Nahra says, "and say, 'I'm representing Dr. So-and-So.'

Direct any requests or communications through me. Let me know if there are any individual employees you want to talk to." I try to facilitate between the employee and the investigator."

Get the investigator's credentials. "Always find out who you're dealing with," Nahra says. "Their authority depends on who they are." If there's more than one investigator, get a name and business card from each one, and find out who's in charge. Work directly with that person.

Designate someone in your office to



"Always find out who you're dealing with. Their authority depends on who they are." — Margit H. Nahra, JD

work with the investigator. Whether that someone is you or the office manager depends on who knows more about your records and who has the cooler head. "Typically the office manager is more knowledgeable about where relevant records are kept," Nahra says, "but if your office manager falls to pieces then you want to get them out of there. You don't want employees who are trying to

be helpful giving copies that might not be final copies or might not be accurate or might be privileged," Nahra says. "It's important to keep control of the flow of information."

Avoid giving investigators originals, including computer files if possible. "I can't tell you how many horror stories I've experienced and seen other people deal with," Nahra says, "where someone will seize original patient records or payment files. Not only is that detrimental to the patients, it can shut down the practice."

Be sure to keep a record of every request the investigator makes and what you give in response.

Answer only questions asked, and provide only requested documentation. "Doctors and their staff frequently forget that the agency has been working on this matter for a long time before they issue an audit request," Nahra says, "and they have particular reasons for requesting what they request. You don't want to confuse them or mislead them or get them interested in additional subjects."

Nahra stresses that initial call to your attorney. Your rights may differ depending on who is doing the audit. Whatever issue brought it on, you don't want to inadvertently create a problem for yourself. — Jan Leibovitz Alloy

Take Action

For more information or for help preparing a plan for future audits, contact your attorney.

FAMILY PRACTICE

OHIO — Wilson Memorial Hospital (WMH) has an excellent opportunity for a Board Eligible Family Practitioner. WMH is a highly respected, not for profit, 112-bed facility located in Sidney. The physician will spend 95% of him time on patient care. Call coverage arrangements provide the physician with quality personal time. Guaranteed base salary of approximately \$130,000 to \$150,000 dependent upon qualifications with production based incentives and an excellent benefit package including medical, dental, life, long term disability, pension, vacation and sick leave. No J 1 opportunities available.

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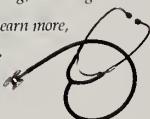
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Your Practice Guide

Hospitals can help you market your practice

Whether it's marketing or networking, your hospital may be able to help you promote your practice.

Hospitals realize they're only as good as the physicians who practice there. Consequently, hospitals are providing an increasing number of marketing services for employee physicians and, to a limited extent, for all affiliated physicians.

Lisa Ovenden is director of Physician Services for ProMedica Health System, a not-for-profit health-care system in northwestern Ohio and southern Michigan. "Medical marketing, to be successful, must be a shared responsibility that isn't limited to people with official 'marketing' titles," says Ovenden. "For instance, physicians are realizing the importance of relationships with other physicians as a form of marketing."

Opportunities exist

Hospitals work hard to bolster hospital/physician relations and inter-physician referral systems. Opportunities include:

- announcements, with photograph, in the hospital's internal newsletter, on internally posted fliers, and on the Intranet;
- staff receptions;
- service in satellite clinics;
- rotation precepting, especially in primary care;
- hospital strategic planning participation;
- timely, automatic feedback processing to your referring physicians.

"Another trend is away from medical specialists sitting in their offices on the campus of a large, tertiary-care institution, and toward the development of services in outlying communities — large or small," says Ovenden.

Friendly faces help personalize an institution's new presence in a community and help build individual practices. This, combined with marketing's increased orientation toward one-to-one relationship building, mean more physician-specific information, including photographs, are being used promotionally.

External marketing tools

Except where limited to employee physicians, almost any practice can

participate in and benefit from hospital-provided external marketing tools, such as:

- new or expanded-practice announcement ads in neighborhood weekly newspapers;
- Yellow Page ads at negotiated rates and within planned formats;
- production and printing of new stationery, business cards and patient information brochures;
- targeted ads in specialty publications, such as a parenting monthly magazine or a senior-activity tabloid;
- public speaking engagements with local groups such as Rotary clubs and parent-teacher associations;
- referral as a quotable media resource, when a health or community issue is being covered that you can address; and
- wellness, injury-avoidance and early-intervention presentations to special-interest groups, such as manufacturing employees on workplace safety, or pregnant couples on prenatal care.

External marketing efforts increasingly address narrower audiences and interests, such as maternity needs, sports injuries and emergency care. You may be able to combine your experience, research, current reading, and personal interests into a

presentation that's fun for you, as well as for your audience. You can act proactively by brainstorming with your hospital's media relations and speakers bureau coordinators.

Some hospitals have contracted with or developed newer modalities, such as:

- automated physician referral by specialty and ZIP code; and
- scheduled-topic Q&A sessions between consumers and physicians via Internet services such as Dr. Koop and America's Doctor Online.

Check outside sources

Promotional opportunities don't always come out of the hospital marketing department. Your nonphysician department head at your hospital may also know the most appropriate people to talk with, formally or informally, about marketing and patient satisfaction issues.

Additional insight into patient satisfaction and practice management improvements can be gained by:

- reviewing your practice profile with the hospital administrator; and
- informally asking other physicians what has worked for them. — Carol Larimer

Legal considerations

Your hospital may be able to help you market your practice, but when it comes to marketing materials, be aware of the following concerns:

- **Superlative descriptions.** Some plans or hospitals may advertise that they, through the listed physicians, provide the best possible care. Such statements could be used to raise the standard of care owed to patients in the event of a malpractice case. In addition, the State Medical Board of Ohio may discipline physicians for making false representations or promises regarding the results of medical services. If an advertisement uses your name and/or photo specifically, ask to see it before it goes to print to make sure it is not making superlative claims about your ability.

• **Physician directories.** A good resource for most physicians. Primary care physicians will want to be listed so patients/enrollees can select you when they sign up. Specialists will want a listing so that primary care physicians know they are available for referrals. But here's the catch. If the directory isn't updated regularly, you may not receive additional patients from the plan. Ask the hospital or plan how frequently the directory is updated.

• **Informational mistakes.** Mistakes can and do occur, and when these are in print, they're difficult to correct. You may want to require that hospitals or plans receive your prior, written consent for the use of your name, practice name, etc., in any advertising and/or promotional material they print. ■

Beware pitching products

The medical board may discipline doctors who agree to multi-level arrangements, selling vitamins, nutritional supplements and other products in their practice.

The State Medical Board of Ohio is currently hearing from a number of Ohio physicians who have been courted by companies that encourage them to become an independent distributor of such items as vitamins, nutritional supplements, and other products. The sales pitch encourages physicians to establish "multi-level" arrangements by recruiting "downline" sales associates.

William Schmidt, the medical board's assistant executive director, has been following these multilevel marketing opportunities.

He says the medical board has reasons for disciplinary action in cases where there is evidence of:

- fee-splitting;
- pyramid sales schemes;
- situations related to the minimal standards of ethics;
- where physicians act in a fiduciary role for their patients.

Ethical concerns

"If a physician recommended a drug that might be wrong, or ineffective, simply because he or she had an interest in it (such as holding stock in the drug manufacturing company), it would be ethically wrong," says Schmidt. Similar standards apply to recommending such items as supplements or other products.

The medical board can revoke or suspend a physician's license for fee-splitting for referrals. This disciplinary statute also applies when a physician sells or recommends a company's products to patients, and subsequently receives a commission on the sales. Such activities may also

Continued on page 21

Your Practice Guide

How to improve patient compliance

The American Heart Association offers you an educational tool kit and patient brochure that may help you improve patient compliance in your practice.

You're probably aware of the statistics:

- 50% of patients aren't compliant with prescription treatment regimens.
- 14-21% never fill their original prescriptions.
- Of 2 billion prescriptions filled each year, about half are taken improperly. The American Heart Association, in partnership with several pharmaceutical manufacturers, have launched an educational campaign on the subject of patient compliance, "America's hidden health threat." Here's what they recommend to improve patient compliance in your practice:

Do:

- Provide verbal and written instruction including the rationale for treatments.

Patients are more likely to take their medication, and/or exercise if they know why it's important to do so. This is especially true if the patient lacks symptoms, and therefore perceives little or no risk to his or her health.

• Involve your patient.

Include your patients in decisions about prevention and treatment goals and related strategies. Tailor treatments to meet their needs. Engage in contracts with them. Negotiate goals and a plan.

• Discuss barriers.

Your patients may be concerned about side effects, or the cost of medication. Maybe the regimen is inconvenient, or too complex for them to follow with assurance. They may be forgetful, or lack social or family support. Ask your patients about barriers. In some cases, you may be able to anticipate them. Then work together to solve these problems.



• Assess patient's compliance at each visit.

Develop a reminder system in your practice to identify and follow-up patients who have a difficult time with compliance. You may want to have your patients use a self-report system, or your office could do telephone follow-up calls. Document in your own records the patient's progress toward the goals you set together.

Don't:

- Assume that compliance is just the patient's responsibility.
- Focus on the patient's symptoms, without also considering prevention strategies.
- Plan your time so tightly that you have no time to discuss compliance with your patient.
- Fail to follow up with your patient.

Toke Action

The American Heart Association offers a "Physician's Compliance Tool Kit" which includes the AHA's Primary and Secondary Prevention Guidelines, a compliance poster, a patient pledge form, and a compliance booklet for patients. To order the tool kit or just the patient booklet, fax your request to: "Knock Out America's Hidden Threat," (214) 706-5233, or call (800) 242-8721.

Beware

Continued from page 20

breach the physician's code of ethics. As Schmidt points out, treating a disease or condition with a product whose efficacy is not well supported by scientific evidence also brings the situation back to the "minimal standards of care" factor. In addition, Ohio law prohibits pyramid schemes and punishes this offense with the threat of criminal prosecution.

AMA: Prepare to disclose

In June, the AMA's Council on Ethical and Judicial Affairs recommended that health-related products should not be sold if the benefit claims lack validity. Another caution was issued against selling any "exclusive" product that would only be available in the physician's office and not have a competitive product offered by independent merchants or pharmacies. It further recommended that physicians be prepared to disclose their financial connection (if any) to all products for sale in the office.

Schmidt says, "The fallacy with multilevel and pyramid schemes is the importance of getting people under you. It doesn't work the way it's promised to work." And in an effort to sell products, physicians doing multilevel marketing may open themselves up to making false statements.

Schmidt says if a doctor makes a statement about a product, and it's false, then it could become a disciplinary action. That's because physicians who put their names to a product by selling it in their offices lend credibility to the product. Conversely, if the sales representative makes the same sort of statement, it can be dismissed as "puffery."

There is an argument to be made on behalf of product distribution. Proponents say that, in the jungle of

supplements, alternative devices for treating diseases or conditions, and commercial products for health and safety, the physician can provide welcome advice.

Physicians' best bet is to realize the pros and the cons, the realities and the risks, and make his or her decision about multilevel distribution accordingly. — Yvonne H. Burry

Ohio Medicine

A Publication of the Ohio State Medical Association

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Ohio Medicine, ISSN 0892-2454 (USPS 402-200) is published monthly by the Ohio State Medical Association, 3401 Mill Run Drive, Hilliard, Ohio 43026. Periodicals postage paid at Hilliard, Ohio and at additional mailing offices. POSTMASTER: Please send address changes to Ohio Medicine, 3401 Mill Run Drive, Hilliard, Ohio 43026.

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Colleagues

Newsmakers

MICHELLE ANDREWS, MD, Cincinnati has been elected to the board of trustees of the Women's Sports Foundation, a national nonprofit organization dedicated to increasing opportunities for girls and women in sports and fitness and consisting of some of America's greatest female athletes.

JAMES AUGSBURGER, MD, Cincinnati, has been appointed Ben and Louise Tate Professor and chairman of the University of Cincinnati Department of Ophthalmology. Dr. Augsburger is involved in new ophthalmic research projects, through the department's Quest for Vision Research Program, involving retinoblastoma, and malignant melanomas, along with his vision for the future of the UC Department of Ophthalmology.

Portrait

Thomas Todd, MD, has a history of volunteering. That's how this family practitioner says he became the mayor of Glendale.

Upon moving to Glendale, a village of 2,500 people, in 1964, Dr. Todd says he admired those on the village council and saw them as role models. "I never really thought that someday I would become mayor," reflects Dr. Todd.

Yet, as a family physician, Dr. Todd realized he had the makings of a good politician. "I'm a professional listener. I listen to people all the time and then decide the best course of action," he explains.

Since 1992, Dr. Todd had served as a council member in Glendale. This past January, he was appointed vice mayor after the acting vice mayor resigned and was then named mayor, as the incumbent mayor resigned during

MELODIE BLACKLIDGE, MD, Cincinnati, received a Caring Angel Award from the Caring Program for Children. Dr. Blacklidge received the Caring Doctor Award from the organization last year. Although she was nominated again this year for the award, she was ineligible to win two years in a row.

SALLY BROOKS, MD, Cincinnati, has been named medical director for the government products division of Anthem Blue Cross and Blue Shield.

EVELYN HESS, MD, Cincinnati, recently took office as governor of the Ohio Chapter of the American College of Physicians-American Society of Internal Medicine (ACP-ASIM). Dr. Hess was elected to a four-year term by the Ohio Chapter membership. She currently serves as an adviser to the ACP-ASIM publication Journal Club, on the publications committee, and as a member of the Ohio Chapter health and public policy committee. Dr. Hess is a

the same meeting.

As mayor, he is in charge of the police department that employs 700 officers and the volunteer fire department that operates two fire trucks. Dr. Todd also holds mayor's court twice a month where, as judge, he presides over cases involving traffic violations and other legal infractions.

Dr. Todd balances his duties as a family physician and mayor by working three and a half days at Springdale Family Medicine and meeting with the village administrator two to three times a week to discuss village concerns. "The hardest thing I've had to do since I've been in office was demoting the police chief for not doing a good job," says Dr. Todd.

In November, he will run for election while simultaneously proposing a bond levy to raise \$2.5 million to fund the village sewer project. As Glendale approaches 105 years old, the storm sewers predate 1950's code.

professor of medicine at the University of Cincinnati Medical Center.

MOLLY KATZ, MD, Cincinnati, received the Great Rivers Girl Scout Council's Woman of Distinction Award for 1999. The awards go to five women who have demonstrated strong initiative, individual integrity and personal leadership in meeting vital community needs.

STANLEY J. LUCAS, MD, Cincinnati, the Health Foundation of Greater Cincinnati elected Dr. Stanley J. Lucas as one of six trustees. Dr. Lucas, a past president of the Ohio State Medical Association, recently retired from private medical practice. The Health Foundation awards grants to nonprofit and government organizations.

MELVIN NIZNY, MD, Cincinnati, is president of the Ohio Psychiatric Association. Dr. Nizny took office in May.

Obituaries

AARON S. CANOWITZ, MD, Columbus, OH, Ohio State University College of Medicine, Columbus, OH, 1929; age 91; died July 12, 1999.

CHARLES A. DILLE, MD, Dayton, University of Cincinnati, College of Medicine, Cincinnati, 1940; age 85; died Aug. 2, 1999.

G. THOMAS DRAKE, MD, Columbus, OH, Ohio State University College of Medicine, Columbus, OH, 1953; age 73; died July 13, 1999.

WILLIAM H. EBERLE, MD, Chagrin Falls, OH, Cornell University Medical College, New York, 1934; age 89; died July 13, 1999.

RALPH J. FINTZ, MD, Westlake, OH, Loyola University Stritch School of Medicine, Maywood, Ill., 1941; age 85; died June 7, 1999.

SIDNEY C. FOSTER, MD, Akron, OH, State University of NY Upstate College of Medicine, Syracuse, NY, 1946; age 77; died June 18, 1999.

MILTON FRIEDMAN, MD, Akron, OH, Case Western Reserve University, School of Medicine, Cleveland, 1930; age 94; died July 14, 1999.

BENJAMIN WILSON GILLIOTTE, MD, Westerville, OH, Ohio State University, College of Medicine, Columbus, OH, 1950; age 79; died June 9, 1999.

WILLIAM B. HARRIS, MD, Columbus, OH, Ohio State University, College of Medicine, Columbus, OH, 1937; age 87; died July 11, 1999.

ROGER E. HEERING, MD, Columbus, OH, University of Michigan Medical School, Ann Arbor, MI, 1933; age 89; died July 17, 1999.

CARL J. HEITZ, MD, Richmond, VA, St. Louis University School of Medicine, St. Louis, 1943; age 80; died July 3, 1999.

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October 1999

A Publication of the Ohio State Medical Association

Ohio Medicine

OSMA decries tort ruling

The Supreme Court ruled Ohio's tort-reform law unconstitutional

Ohio's tort-reform law has been supported by the OSMA and the business community. One was too surprised when the Supreme Court struck it down, but what happens now, and how will this decision affect you?



9
The voting in Ohio's Health Professional mortgage areas can provide you with free medical school, but expect the competition to be tough.



10
Physician of the Century, Dr. Clark Clarke, MD, Gahanna, and this summer. He will be issued by all levels of organized medicine...especially the SMA.



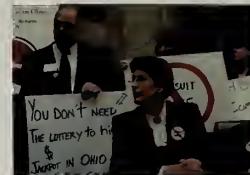
11
HMOs can be a threat to your practice – especially if they are not an firm financial option. Weiss Ratings, Inc. and Ohio Medicine can provide you with a list of the state's riskiest HMOs, according to Weiss.



a physician dies, or becomes incapacitated suddenly, then closing the practice becomes a little complicated. Here's advice for the agent in charge.

Ohio's tort-reform law has been declared unconstitutional by the Ohio Supreme Court. In a 4-3 decision, the court ruled in mid-August that the law violated the Ohio Constitution's separation of powers, as well as a ban against including more than one subject in a single bill.

The OSMA, working as part of the Ohio Alliance for Civil Justice, supported House Bill 350, the tort-reform bill, which passed the Ohio General Assembly in September 1996. The law places limits on noneconomic damages (i.e., pain and suffering) and punitive damages that may be awarded as part of a liability suit. The law was challenged in November 1997 by the Ohio Academy of Trial Lawyers, along with labor representatives. These groups asked for, and



OSMA Past President Claire Wolfe, MD, center, took an active role on behalf of the OSMA in supporting the tort-reform bill. Here she participates in a rally held shortly before the bill became law.

received, an expedited review of the new law. Many court watchers felt that expedited review was unwarranted in this case, and that the new law never had the opportunity to be legitimately tested.

"We clearly demonstrated to the Ohio

Continued on page 3

HMO doctors can't be disciplined for decisions

In an opinion written for the State Medical Board of Ohio, Attorney General Betty Mangam says that HMO doctors don't practice medicine when they review medical claims.

Attorney General (AG) Betty Montgomery told members of the State Medical Board of Ohio late this summer that they may not discipline doctors – hired by HMOs to review claims – for making bad decisions. She wrote in her opinion, requested by the board in February, that Ohio law states that insurance company doctors don't practice medicine when they review medical claims.

The board had asked the AG for an

opinion to clarify its authority over HMO doctors who sign off on inappropriate coverage denials. The board said they already have such jurisdiction over doctors employed by insurance companies. Montgomery wrote, however, that actions taken by health insuring corporations are not considered to be the practice of medicine, reinforcing the insurance industry's argument that utilization review

Continued on page 4

How justices voted

The OSMA believes it's important for you to know how the Ohio Supreme Court Justices voted in their decision to strike down Ohio's tort-reform law.

The following justices concurred with the majority view:

Justice Alice Robie Resnick – Wrote the decision. See main story for her comments.

Justice Andrew Douglas

Justice Paul Pfeifer – "To delay judicial review of the (constitutional issues) the bill raises would compound the damage to injured parties."

Justice Francis E. Sweeney

The following justices dissented from the majority view:

Chief Justice Thomas Moyer – "The majority opinion makes the Supreme Court the 'remedy of choice' in seeking relief that should come from Ohio's trial and appeals court. I cannot condone the majority's willingness to sweep aside these established common-law principles which date from the time of Elizabethan England."

Justice Deborah L. Cook

Justice Evelyn Lundberg Stratton – "The majority should have allowed provisions of HB 350 which met constitutional challenge to remain in effect, severing them from invalidated provisions."

Two justices will be up for election in November 2000: Justice Alice Robie Resnick and Justice Deborah Cook.



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Bills, Laws & Rules

In perspective

Righting the wrongs – next steps

The OSMA strongly disagreed with the Supreme Court when it declared Ohio's tort-reform law unconstitutional. Here's why...and what steps the OSMA will take now.

One is any hope of tort reform – at least for now. With last August's total rejection of a major legislative package aimed at putting common sense in our legal system, organized medicine is considering its options. "We are now considering whether we pursue legislation again or take the more political route and get involved in the judicial elections," says Tim Maglione, director of OSMA Department of Legislation. Maglione certainly sees the possibility of re-in-

troducing tort reform in an upcoming legislative session. An alternative strategy would have been to appeal the court's decision. But that action would probably yield the same rejection, Maglione says, since the four judges on the high court who rejected the state's tort-reform law form a majority, and would likely repeat their vote, if challenged.

Even with vigorous dialogue and support, a win for tort reform has been an elusive goal. Organized medicine had supported such issues as the cap on noneconomic damages, a statute of repose, and the proposed changes for



joint and several liability. "Without these measures, we will continue to have a lot of unpredictability in our civil justice structure," says Maglione. "Because these measures were thrown out of the legislative package, they very well could see higher medical malpractice costs and an overall increase in health-care expenditures. Physicians will no doubt have to practice more defensive medicine and incur higher office overhead costs due, in part, to professional liability protection."

Tort's key components

A cap on noneconomic damages had been designed to "place outer limits or parameters on damages like pain and suffering, and loss of companionship – things that are difficult to quantify in an

economic damage sense," says Maglione. By contrast, *economic damages* – medical expenses, wages lost, training required to re-enter the workforce these are much easier to quantify, he says.

"The previous law set a sliding scale of \$250,000 to \$1,000,000 for noneconomic damages. Such a cap would not affect economic damages," says Maglione, "but would add more predictability to the system and would help stabilize professional liability premiums." With a cap, the total possible economic and noneconomic damage ranges would be known, which would tend to encourage out-of-court settlements, and save time and money.

The statute of repose confronted the issue of how much of a look-back period is appropriate for incidents where malpractice is the concern. "The present statute of limitations says you have to file a claim within one year of the date of injury," says Maglione. The "discovery rule" part of this statute refers to patient's having known, or should have known of the harm, even though the harm didn't manifest itself right away. If this discovery comes a decade or more after a procedure, it becomes very difficult to locate

Continued on page 6

Tort ruling

Continued from page 1

General Assembly the need for tort reform in this state, and helped craft a law that prevented abuses of the system without effectively limiting an injured person's right to sue," says Tim Maglione, JD, director of the OSMA Department of Legislation. "The Legislature made a policy statement when it passed tort reform, and we heard a lot of witnesses telling about the benefits of tort reform. Particularly in medical situations, there is clear evidence that this type of reform helps lower the cost of health care."

Overstepping bounds

The Supreme Court, however, defended the expedited review system, and criticized legislators for overstepping their bounds in passing the law. Justice Alice Robie Resnick, writing for the majority, said that lawmakers defied the judiciary by enacting a law that contained provisions that had al-

ready been rejected by the justices. "It marks the first time in modern history that the General Assembly has openly challenged this court's authority to prescribe rules governing the courts of Ohio, and to render definitive interpretations of the Ohio Constitution binding upon the other branches," she wrote.

Chief Justice Thomas Moyer, writing for the minority, countered that his colleagues on the bench appeared to be "throwing down the gauntlet to that equal legislative branch of government," adding, "It is time to end this war of words."

Another bill?

Meanwhile, legislators remain unswayed by the Supreme Court's sharp words. In a joint statement released after the court's decision, Senate President Richard H. Finan (R-Cincinnati) and House Speaker Jo Ann Davidson (R-Reynoldsburg) said: "We continue to

believe that tort reform remains in the best interest of all Ohioans in order to curtail the filing of frivolous lawsuits. We also believe that there is significant support in the Ohio General Assembly to craft another tort-reform bill, which is the prerogative of the Legislature."

AG wants clarification

Attorney General Betty D. Montgomery has also asked the Supreme Court for clarification on the state's tort-reform law. Specifically, Montgomery wants to know who has the right to bring an original cause of action in the Supreme Court. "It seems to allow any citizen to challenge any legislation, whether or not he is directly affected," she says in a report included in a recent issue of the *Gongwer Report*. "Such a broad holding belies any claim of mutual respect for the other branches of government." With regard to the separation of power issue, Montgomery wants to know whether the

Legislature will be permitted to respond to future Supreme Court decisions.

Maglione predicts the current majority will not be inclined to reverse the decision on the overall tort-reform case. "But they may provide some clarification regarding the questions raised in consideration."

Still, he continues, "It is very unfortunate for the people of this state that the Ohio Supreme Court, by an extremely narrow margin, has voted to strike down this law. We continue to believe that tort reform is needed and necessary and will explore other options to protect the people of Ohio." ■

For a more detailed look at tort reform, and what happens now that the law has been struck down by the Ohio Supreme Court, see story above.

HMO doctors

Continued from page 1

is a reimbursement decision, not a medical one.

Patients are vulnerable

The passage of House Bill 4 this summer, an OSMA-supported "Patient Protection Act," allows patients the right to an independent, external review when they differ with HMOs and their doctors over a coverage denial. Yet despite this safeguard, patients' inability to sue their HMO over denials and the medical board's inability to discipline HMO doctors who make bad decisions leave Ohio HMO patients especially vulnerable.

The OSMA, of course, disagrees strongly with the AG's opinion. "If these doctors aren't accountable to the medical board, then who are they accountable to?" asks Tim Maglione, OSMA legislative director. "And if it's not a medical decision, why do we require a doctor to make the call? Why not require an accountant to make it? I think this rekindles the debate over whether or not a patient has a right to sue an HMO." A provision that gave patients that right was dropped from HB 4 before it became law. "What remedy does a patient have if the HMO makes a bad medical decision?" Maglione asks. "The Legislature will have to ultimately deal with that."

Pending complaints

For now, however, the medical board is left to deal with dozens of pending complaints against HMO doctors – and no authority to discipline doctors who may be at fault for making bad decisions.

"We have been working over the past several years with the Ohio General Assembly to restore balance to the health-care system," says OSMA President David J. Utak, MD. "To suggest HMOs are not accountable to the state medical board when making medical necessity determinations is a setback to these efforts.

"In our opinion, health plans are clearly practicing medicine when they review the charts of individual patients and decide whether the treatment or procedure recommended by those patients' personal physicians are medically 'necessary.'"

The OSMA is still reviewing the opinion and will consider its options for having the issue readdressed. ■

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OMPAC can impact your practice significantly

If you don't contribute you can expect more regulations, more restrictions and expanded scopes of practice for more allied medical groups who already have a number of friends at the Statehouse.

Think of it this way: You can avoid politics – but by doing so, you're jeopardizing the way you practice medicine. That's because each legislative session, dozens of health-care bills are discussed some good, some not so good – but, if passed into law, they will definitely affect the way you practice medicine.

To optimize the effect of these bills for both your patients and the profession, it's necessary to have a few friends at the Statehouse. That's not crass or cold. It's politics, and you should know that a number of other health-care groups – the nurses, optometrists, chiropractors and other allied medical groups – are making friends as well. Lots of them.

The problem is, however, friends just aren't as easy to make at the Statehouse these days. Term limits mean a

constant turnover in the Legislature, and some of medicine's most important friends will soon be leaving.

That means the Year 2000 elections are more important than ever. This is where you come in.

In order to ensure that medicine can be assured of legislators who will listen – not only to medicine but to patients – it's vital that you support those candidates who can understand and are sympathetic to medicine's position.

The best, most effective and efficient way to provide this support is by contributing to the Ohio Medical Political Action Committee: OMPAC. OMPAC researches the candidates for you and puts your money where it will do the most good. Incidentally, OMPAC has a "300 Club," reserved for OMPAC contributors who pay \$300 or more and who want to assure that medicine contributes to have friends in high places.

In this issue, you'll find an insert listing names of OSMA members who are OMPAC supporters. Members of the "300 Club" are in boldface type.

The OSMA and the OMPAC Committee, chaired by Dan Handel, MD,

Youngstown, hope you'll add your name to the list. If it's not too forward, they'd like you to consider adding your name in boldface type.

Of course, you can avoid the whole matter. You can choose not to become involved in politics...not to spend your money on such an "intangible" benefit. But without support at the Statehouse, you can't expect bills like last year's Physician-Health Plan Partnership Act or this year's Patient Protection Act to pass – both managed-care reform measures that have already started to make improvements in the way medicine is practiced in Ohio. You can expect, however, to find more regulations, more restrictions on your practice, and expanded scopes of practice for more allied medical groups.

Still, the decision is entirely up to you. ■

Take Action

To join the Ohio Medical Political Action Committee, contact Krista Bistline, Department of Legislation, (800) 766-6762, Ext. 6748.

Tort reform

Continued from page 3
records, find people involved, or even recall memories of that incident.

With the proposed statute of repose, a six-year limit from the date of the procedure or service would have put some boundaries on the discovery rule.

The joint and several liability is used addressed the multiplicity of defendants and their financial penalty in liability judgments. In current cases, if several defendants were named, the amount of involvement in the adjudged action and the amount of financial penalty incurred were sometimes very different. A physician who was only 10% at fault could end up paying 100% of the penalty.

"The OSMA felt that everyone should be responsible for his or her own actions," says Maglione. "If someone was 10% at fault, that should equal 10% of the damages, in proportion to the liability."

The fallout

Another result of last summer's decision may be what Maglione calls a "constitutional crisis."

"The high court seems to have taken on the responsibilities delegated to the legislative branch, for example making policy judgments. It's a simple civics lesson," Maglione explains. "Each branch of the government has a role, each should be a co-equal, and each should have equal power. We might not be there today."

"It's almost as fundamental as our democracy that we have co-equal balance among the three branches of government," Maglione adds. "The court seems to see themselves as the final arbiter of what is good public policy, and not necessarily in a constitutional reference." Thus if the high court interprets its duty as *making laws* rather than leaving that responsibility to the Legislature, then a basic tenet of the American political structure may be in question. —Yvonne H. Burry

Take Action

Your comments on tort reform should be voiced to your legislators. For assistance and information, contact the OSMA Department of Legislation, (800) 766-6762.

Don't sign forms unless you've seen patient

The State Medical Board of Ohio tells licensees if they sign pre-printed insurance forms, they must provide the service, or they may be violating the Medical Practice Act.

Be careful with the way your practice handles pre-printed insurance forms.

The summer issue of the State Medical Board of Ohio's newsletter *Your Report* says that the board has received numerous complaints about physicians who "falsely reported their activity for the purpose of securing payment from third-party payors."

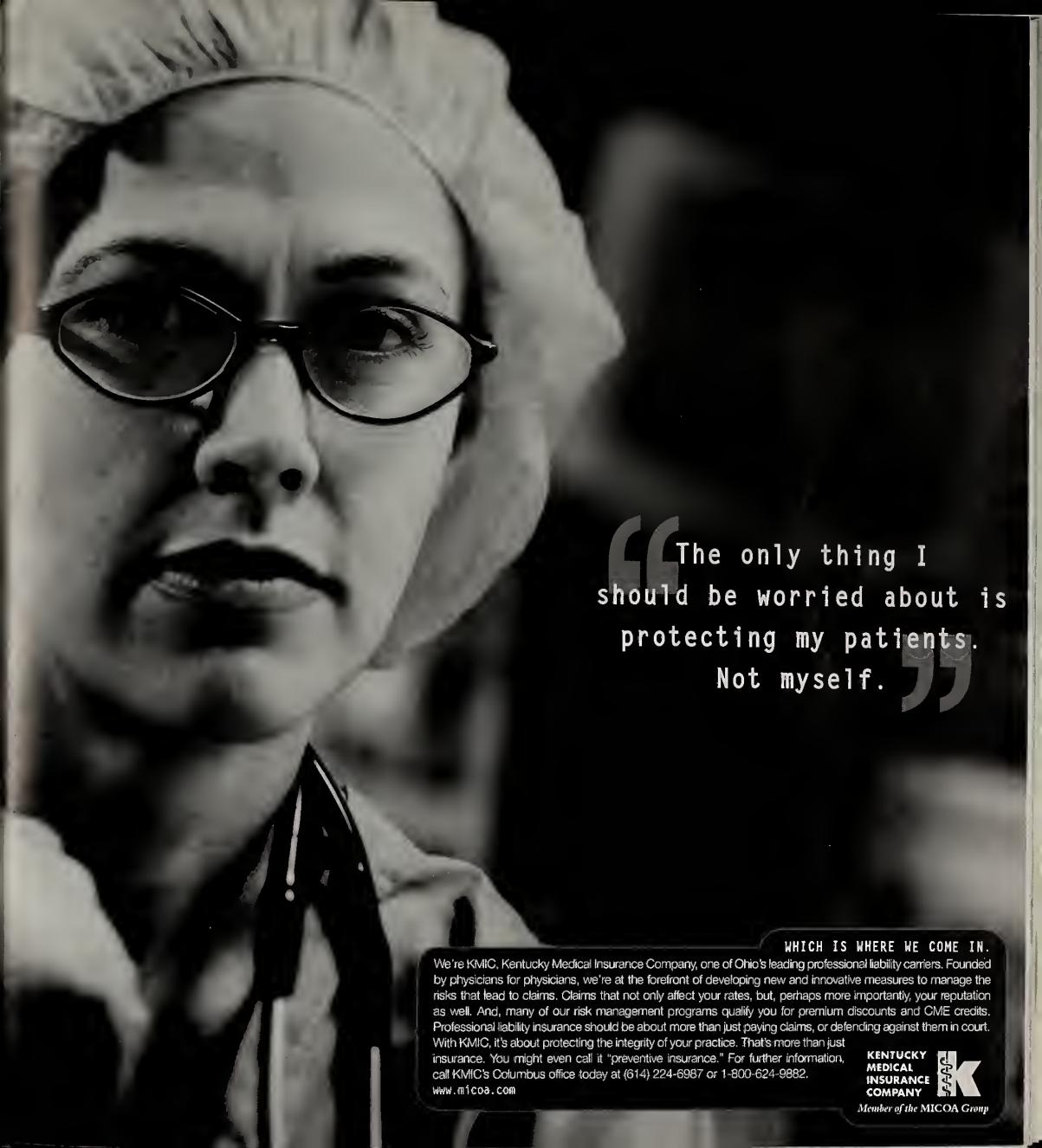
The article, actually the board's policy statement on "Physician Statements on Reimbursement or Billing Documents," continues to say that these complaints generally involve the physician affixing his or her signature (or allowing it to be affixed) to a pre-printed insurance form in situations where the physician didn't personally provide the services for which payment is sought.

The board advises licensees that the certifications a physician makes on reimbursement or billing documents to statements made in the course of practicing medicine, and such statements may violate certain provisions of the Medical Practice Act if they are not presented honestly.

Medical Board Report

"Where a physician is confronted with a pre-printed billing form which asks for a certification not in accord with the physician's actual activities, the physician should either refuse to sign the certification or change the certification such that it does convey the physician's actual activities," says the piece.

The board further advises physicians



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Committee studies patient access to plans

A legislative study committee is charged with studying patient access to health-care plans, and will issue a final report on Dec. 31. Two physicians have a seat at the table.

One of the many bills to be signed into law in the waning days of the last session was Sub. HB 16, sponsored by Rep. Don Mottley (R-New Carrollton), which creates a task force to study the health-care marketplace in Ohio. The task force is charged with completing a study on the availability and cost of open panel insurance products in Ohio and report the findings to the governor and the Legislature by Dec. 31.

The task force's specific charge is to study patient access to preferred provider plans, point-of-service plans, and other open panel plans for health-care insurance coverage. Their job is to collect data to determine whether those types of health-care plans enhance or impede consumer access to quality and affordable health care. "Point-of-service remains a popular issue for both physicians and patients," says Nick Lashutka, OSMA Deputy Director of Legislation. "Point-of-service allows patients to select the physician of choice, usually for some additional out-of-pocket cost, which doesn't compromise the basic tenets of managed care."

At issue, of course, is the amount of the out-of-pocket cost incurred by the patient who selects a physician outside of the managed-care network, which is reflected in either a copayment or deductible. "Any cost borne by the patient needs to be based on sound actuarial data," says Lashutka. "If the point-of-service option is priced beyond the actuarial value, it becomes a paper option and will be too expensive for anyone to afford."

The task force was created when Gov. Taft signed this bill into law on June 15, and represents a compromise on the issue, Lashutka explains. "Leg-

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Indepth Report



Incentive programs draw physicians to underserved areas

Health Professional Shortage Areas exist in both rural and inner-city areas of the state. They look more attractive when loan forgiveness or scholarships enter the picture.

Each time physicians renew their medical license, they pay a fee — attached to all Ohio medical licenses — that helps fund the Ohio Physician Loan Repayment Program. The program helps primary care physicians repay medical school loans in return for service in underserved areas.

Ohio has 66 communities designated as Health Professional Shortage Areas (HPSAs). Because their population-to-primary-care-physician ratios exceed those specified by the federal Division of Shortage Designation, those areas are eligible for assistance in recruiting primary care physicians. Although the types of underservice in Ohio have shifted over the years, the number of shortage areas has remained fairly constant. "Some rural areas in particular have beefed up their ranks of primary care physicians," says Coleen Schwartz, recruitment/retention coordinator of Ohio's Primary Care and Rural Health Program, "but maybe nobody's seeing the low-income population in that community."

Free medical school

HPSAs look more attractive when loan forgiveness or scholarships are thrown into the mix.

National Health Service Corps scholars receive free medical school and a small stipend in return for two to four years' service in a HPSA. Not surprisingly, "It's extremely competitive to get one of those scholarships," says state primary care analyst Mary Lou Owens. The corps also offers loan re-



Even the urban areas of Columbus are underserved.

payment of up to \$120,000, including loans for undergraduate school, for HPSA service. The Ohio Physician Loan Repayment Program is similar to the federal program but limits loan repayment to \$80,000, for medical school only. And eligibility for the Ohio program is confined to physicians in family practice, general internal medicine, general pediatrics, and obstetrics/gynecology; the federal program also includes advanced practice nurses, physician assistants, dental and mental health professionals.

New definitions of HPSAs, currently in the works, may affect the federal incentive programs. The Health Resources and Services Administration is revisiting changes it proposed last year after receiving more than 800 letters of protest. (See "Rules changes for underserved populations are on hold," *Ohio Medicine*, June 1999.)

Making a good dent

Twenty-five to 30 primary care providers are placed in Ohio HPSAs each year through the state and federal programs, Owens says. "It's certainly not solving the problem completely. I think it makes a pretty good dent. It's not always easy to find people who want to serve in underserved areas."

"A lot of what you see," Schwartz

says, "is people who have a service orientation, either through a personal commitment to that kind of thing or through some experiences they've picked up while in their training — being exposed to underserved populations through medical school or a residency program." National Health Service Corps rotations and summer experiences in HPSAs, she says, "open their eyes to the need in these kinds of areas, things that they might not have thought were even in Ohio. Maybe [they thought] Appalachia meant only the deep South. The urban areas of even Columbus are underserved. It's not just New York City."

Rural, inner-city available

Physicians preparing to serve in HPSAs through the state and federal programs may choose from site lists that contain both rural and urban areas. Some base their decision on where their families are. Others are attracted to a rural lifestyle. Ohio's HPSAs are fairly evenly split between inner-city and rural areas, Schwartz says.

There's no perfect way of knowing if physicians stay in underserved areas after their service is finished, she says. Tracking systems for the programs "have not been fully developed and implemented." And physicians no longer in the programs have no incentive to report. — Jan Leibovitz Alloy

Take Action

For more information, contact Mory Lou Owens, state primary care analyst, (614) 752-4479, or Coleen Schwartz, recruitment/retention coordinator, Primary Care and Rural Health Program, (614) 644-8496.

Ohio's shortage areas

(Listed by county then service area/population group/area/facility)

Adams	Cadiz/Scioto/Hopewell
All	Henry
Ashland	Medically indigent
Orwell	Highland
Athens	Low-income
Medically indigent	Hocking
Brown	Medically indigent
All	Holmes
Butler	Low-income
Eastern Hamilton	Jackson
City	Low-income
West Middletown	Jefferson
Carroll	East Liverpool
All	Lawrence
Clark	Low-income
Southwest side	Lucas
(Springfield)	Center City/Dorr
Clermont	East Toledo
Eastern Clermont	Near Southside
Colombiana	Mahoning
East Liverpool	Eastside Youngstown
Coshocton	Southside
Low-income	Youngstown
Cuyahoga	Meigs
Near West/Westside	Monroe
Edgewater	Woodfield
Medically indigent	New Matamoras
Clark	Montgomery
Fulton/Denison/Trenton	Homeless of Dayton
Low-income of	West Dayton
Central/Pearl/Kinsman	Morgan
Western Collinwood	All
Hough/Norwood	Morrow
Glenville	Perry
Mt. Pleasant/Union-	All
Miles Park/Corlett	Pike
Lee Miles	All
East Cleveland	Portage
Free Clinic of	Medically indigent
Greater Cleveland	Preble
Fairfield	All
Low income	Putnam
Lancaster/Baltimore	Medically indigent
Fayette	Richland
Low-income	Medically indigent
Franklin	Sandusky
Franklin	Low income/migrant
Low-income	farmworkers
Lower Linden-N.E.	Scioto
Near North/	Low-income
University	Seneca
Near Southside	Low-income
Guernsey	Stark
Cambridge	NE Canton
Freepoort	Summit
Hamilton	Akron (Southeast Side)
East and Lower Price	Trumbull
Hill/South Fairmont	Orwell
Winton Hills	Warren/The Flats
Millvale	Tuscarawas
East End	Freeport
West End	Vinton
Hancock	All
Low-income of	Washington
Tiffin/Fostoria	New Matamoras
Hardin	Wood
All	Low-income of
Harrison	Tiffin/Fostoria
Freeport	

OSMA News

OSMA "Physician of Century" dies

Oscar W. Clarke, MD, Gallipolis, died Aug. 16 at home following a brief illness.

Dr. Clarke was a longtime friend of the OSMA, and organized medicine in general. The OSMA presented Dr. Clarke with a Distinguished Service Award in 1988, and in 1996, the association named him "Physician of the Century" in recognition of his decades of leadership, including his service to patients.

His involvement with the OSMA was extensive. In addition to serving as president from 1973 to 1974, Dr. Clarke also served as president of the Ohio delegation to the AMA, as Ninth District Councilor, on numerous committees, and was a member of OMPAC's "300 Club." Dr. Clarke was also active in the OSMA-affiliated Ohio Medical Education and Research Foundation (OMERF), serving as its chair from 1983-1996.

On the national level, Dr. Clarke served as chair of the AMA's Council of Ethical and Judicial Affairs.

Dr. Clarke's other leadership activities included: a term as president of the State Medical Board of Ohio; eight years as president of the Holzer Clinic in Gallipolis; a trustee of the Holzer Hospital Foundation and the Veterans Memorial Hospital in Pomeroy. He was serving, most recently, as the medical director of the Holzer Hospice Organization in the Gallipolis area, and as a trustee of the Holzer Hospital Foundation.

In a memo to Holzer Medical Center staff, notifying them of Dr. Clarke's death, J. Craig Stratford, MD, president, and Robert E. Daniel, administrator, wrote: "Dr. Clarke was an active and loyal group member for more than 25 years, and provided outstanding leadership as president to our organization



Oscar W. Clarke,
MD

during a time of growth and expansion from 1981 to 1989. It was during his presidency that we actively expanded into our branch clinics and it was also during this period of time that we purchased and expanded to our main facility. Dr. Clarke was a mentor to many of us, and he will be sadly missed."

His community involvement included the Gallipolis Rotary Club, the Gallipolis City Board of Health, and the Gallia County Heart Association. During World War II, he served with the U.S. Air Force Medical Corps in Wiesbaden, Germany.

Dr. Clarke, a native of Petersburg, Virginia, received his medical degree from the Medical College of Virginia in 1944 and completed an internship at Boston City Hospital. He returned to the Medical College of Virginia for his residency in internal medicine. He and his wife, Susan, moved to Gallipolis in 1950.

Dr. Clarke is survived by two of his three daughters and four grandchildren,



Almeta Cooper joins staff as OSMA counsel

Almeta E. Cooper, JD, has joined the OSMA as its general counsel. In this position, she will serve as the association's chief legal counsel, and will be responsible for directing the association's Division of Legal Affairs.

Cooper, a graduate of Northwestern University School of Law, brings a wide variety of legal, graduate medical education and health-care system experience to this position. She most recently served as senior counsel of Philadelphia's MCP Hahnemann University which includes the Schools of Medicine, Nursing, Health Professions and Public Health.

Prior to joining Hahnemann, Cooper was senior counsel and vice president, Office of the General Counsel, Allegheny Health, Education and Research Foundation, also in Philadelphia. In Nashville, Tennessee, she served first as corporate secretary and general counsel of Meharry Medical College, and then as general counsel of St. Thomas Hospital.

Cooper also has medical association experience. Earlier in her career, she served as the assistant director of the Health Law Division of the American Medical Association (AMA) Office of the General Counsel. At the AMA, she was the legal counsel for the accrediting bodies for medical schools, the Liaison Committee on Medical Education, and for graduate medical education, the Accreditation Council for Graduate Medical Education.

"I am looking forward to working at the OSMA," says Cooper. "I was particularly attracted to OSMA because of its strong record of advocating for the physicians and the patients of Ohio."

Cooper received her undergraduate degree in German from Wells College, Aurora, New York. She is an active member of numerous professional and civic associations, including currently serving on the Board of Directors of the American Health Lawyers Association. ■



Almeta
Cooper,
JD

Award-winning StAT heads north

The OSMA's Statewide Advocacy Team (StAT) will be in northeast Ohio early this month, visiting medical staffs in Parma, Fairview Park and Lake County. StAT members travel throughout the state, visiting hospitals and group practices to provide physicians with the latest legislative, legal and reimbursement news, tailored specifically to address their concerns. The group will be in Parma on Oct. 5, and later that day will travel to Fairview Park. On Oct. 6, StAT will be in Lake County at Lake West Hospital, and on Oct. 7, StAT will meet with the staff at University Hospitals of Cleveland.

StAT was presented with the 1999

Merit Award in Technology by the Ohio Society of Association Executives at the society's annual conference in August. Doug Evans, director of OSMA Membership Services, accepted the award on behalf of the OSMA.

In addition to providing updates on issues important to medicine, StAT also explains the tangible member services offered by the OSMA and organized medicine. Autumn dates for StAT visits are filling quickly. If you are interested in a StAT visit to your hospital or group practice, or would like more information about the StAT program, contact Lucy Kitner, (800) 766-6762, Ext. 6776. ■



Awards presented to 4-H health day winners...The OSMA was on hand at the Ohio State Fair as sponsors of the 4-H Health Day contest. Pictured here are "Health and Safety" winners Danielle Stockham (left), Madison County and Jondi Vest-Gibbs, Fayette. Both were winners in the junior division.

Workshop offers tips on taming the small practice

If you're a solo practitioner or a member of a small (three or fewer) group practice, you already know how difficult small medical practices are to manage. However, there are still many things you can do to make your day more organized...employees more productive...and the business more profitable.

That's why the OSMA is sponsoring a seminar, presented by Adams & Associates, entitled "Managing in a Small Medical Practice." The full-day workshop will be held in November at various locations around the state (see "Take Action" below.)

Among topics to be reviewed at the workshop are:

- Designing a personnel policy manual;
- Basic business techniques for the medical office setting;
- Accounts receivable management – improving your revenue position;
- Overhead management – cutting unnecessary expenses and increasing your profits;
- Front desk and patient flow management;
- Functions, skills you should consider outsourcing.

The seminar is specifically targeted for physicians, office managers and business administrators in medical practices with three or fewer providers. Costs are as follows:

- **OSMA members and staff,** one enrollee, \$185 per seminar; \$165 (each) per seminar for two or more enrollees
- **Nomembers and staff,** one enrollee, \$285 per seminar; \$265 (each) per seminar for two or more enrollees.

Take Action

The "Managing in a Small Medical Practice" workshop will be offered: Nov. 9, Cincinnati, Kings Island Resort and Conference Center; Nov. 10, Columbus, OSMA headquarters; Nov. 11, Toledo, Radisson Hotel Toledo; Nov. 12, Cuyahoga Falls, Sheraton Suites; if you would like to register to attend the workshop, contact Amy Johnston, OSMA Department of Meeting Management, (800) 766-6762, Ext. 6726.

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OHIO STATE MEDICAL ASSOCIATION

OPPORTUNITIES TO PARTICIPATE

You have useful expertise, experience and ideas on how issues should be handled by your association. Often times, however, you just don't have the time for long-term involvement. The OSMA now has a way for you to take part in shaping association programs and policies without a major commitment of time.

For many issues, the OSMA doesn't need standing committees whose members meet face-to-face on a regular basis over a period of years. Issues often arise quickly and physician expertise is needed to review the problem and make recommendations that are then turned over to OSMA staff for expedient implementation. In these situations, focused task forces (FTFs) are the answer. Participants are selected from members with known interests in the issue being studied, responses are often gathered by fax or e-mail and meetings most often are held by telephone conference call. The typical commitment usually lasts for one to three months...not years.

Listed below are broad issues that we anticipate may need to be addressed in 1999-2000. If you are interested in participating on a focused task force, please check the issues of interest to you. Your OSMA biographical record will indicate your interest and you will be contacted as issues arise.

- Anti-Trust/Collective Bargaining
- Bureau of Workers' Compensation
- Emergency and Disaster Medical Care
- End-of-Life Issues
- International Medical Graduate Issues
- Medicaid
- Medicare
- Managed Care
- Pharmaceutical Issues

- Physician Education
- Private Payor Reimbursement Issues
- Public Health
- Rural Health
- Scope of Practice Issues
- Tort Reform
- Utilization Review
- Young Physician (<40) Issues
- Other _____

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Telephone _____ Fax _____ E-Mail _____

Preferred Mode of Communications: Mail Telephone Fax E-Mail

Return your completed form via fax to: (614) 527-6763
or by mail to: OSMA, 3401 Mill Run Drive, Hilliard, OH 43026

President's Perspectives

Focused task forces increase your input

In 1998, OSMA's House of Delegates heard the report of the Task Force 2000. This group, charged with recommending ways to restructure the OSMA for the next millennium, suggested appointing Focused Task Forces (FTFs) to deal with pressing issues as they arise as a more effective means than the committee structure that has been in place for OSMA. The House agreed and formally created FTFs through Action Item G of Report A.



Dr. Ulak

Allow me to elaborate on this concept of a focused task force. It will be the job of the FTF to help identify issues; to analyze them; to propose policy, if necessary. In its work, FTFs will seek input from members and non-members, even nonphysician experts if that's what's needed. They will present progress reports and, finally, make appropriate recommendations to Council for implementing their proposed action plans.

Focused task forces will involve more of you in the decision-making process. Not only will you be able to contact a focused task force member to present your thoughts and opinions, but you'll also be able to volunteer as a task force participant. FTFs have another advantage as well. The process will *increase* the information you receive on any subject the OSMA is confronting without requiring that you consider issues that don't interest you.

Over the last year, I have met with Immediate Past President Lance Talmage, MD, to review the activities of OSMA's current committees, and have concluded that FTFs could effectively replace the majority of these committees. Not all of them, though. As the

continued on page 21



RATING THE MALPRACTICE CARRIERS

October 1999

Editor's note: The following information is reprinted from the initial newsletter to acquaint first-time readers with the purpose of these quarterly reports.

Nationally, despite a strong economy and rising financial markets, 23 insurance companies were taken over by state regulators in 1997, according to statistics compiled by Weiss Ratings, Inc., a leading provider of ratings and analyses on the insurance industry. In all, insurance company failures were up 200% from 1996, when only eight insurers failed.

Property and casualty (P&C) insurers, which provide coverage for homes, autos and businesses, suffered the greatest difficulties, according to Weiss. P&Cs accounted for 19 of the 23 national failures, due primarily to intense competitive pressures. This represents a tenfold increase from 1996, when only two P&C insurers were taken over by state regulators.

When Ohio-based PIE Mutual Insurance Company went out of business in late 1997, its assets were \$281.7 million. During 1996, PIE wrote 30.2% of the medical malpractice insurance coverage in Ohio, according to the Ohio Department of Insurance.

House of Delegates requests ratings

In response to this trend and its consequences, the following ratings chart of selected medical malpractice insurance companies conducting business in Ohio has been requested by the OSMA House of Delegates in Resolution 32-98: "Resolved, that the OSMA publish the ratings of professional liability insurance carriers operating in the state of Ohio at least quarterly, together with a detailed explanation of the meaning and significance of the

assigned ratings, as a basic and timely service to members."

The Ohio Department of Insurance (ODI) reviews and licenses insurance companies that conduct business within the state. Should any of these licensed companies go into liquidation, their obligations will be met, with some limitations, by the Ohio Insurance Guaranty Association (OIGA). The OIGA does not cover unlicensed insurance companies, including surplus line companies, nor reciprocal and interinsurance exchange companies offering malpractice insurance. You can confirm the license status of any company by calling ODI at (614) 644-2647.

OSMA has chosen to use three highly-recognized rating services for the quarterly chart - A.M. Best Company, Standard & Poor's, and Weiss Ratings, Inc. Each rating service uses a multifaceted, proprietary system to analyze the health and strength of each company. According to Dan Kelso, president of the Ohio Insurance Institute (OII), "As thorough as rating reviews are, a well-rated company could still become insolvent quickly if, for instance, that company's management chooses to hide pertinent facts from regulators and rating services."

Ratings can change at any time for many reasons; in addition, a company can be placed on a watch list by a rating service if a major change is anticipated within the company. Therefore, in conjunction with this quarterly chart, OSMA has provided links to the most appropriate Web pages for the three rating services. You can access these from the OSMA Web site (www.osm.org) by using the "Links" button. You will need to be an OSMA member to access the link. Telephone numbers are also listed after the chart. These are easy ways for you to check the ratings for your own in-

surance company or those you are considering, on a more frequent basis.

Check ratings frequently

Rating services also offer research reports on individual companies for a fee; these may be ordered from their Web sites or by phone, and are also available from the insurance company or through your insurance agency.

There is no charge for receiving verbal ratings with Standard & Poor's. However, the A.M. Best Company and Weiss does not charge the companies being rated. The modest inquiry fees are described in this insert and on their Web sites.

Based on 1997 ODI reports, 93 companies (licensed and unlicensed) wrote medical malpractice premiums in Ohio last year. OSMA has chosen to use "premium volume written in Ohio" as the most objective standard for selecting the insurance companies for this chart. The top 16 companies, cumulatively, wrote 88.6% of the medical malpractice premium volume in 1997, and individually, had captured 1% to 19% of the market share.

Size not key to strength

Realistically, according to OII's Kelso, size and market share are not always indicative of strength, service claims-paying ability or price. Consulting your insurance agent, researching current ratings and talking with other physicians regarding service will help to balance any inherent weaknesses of any single evaluation method.

Also included in this quarterly listing are those medical malpractice insurance companies that advertise in *Ohio Medicine*, or those represented by insurance agencies that advertise.

The ratings reported in the chart are represented with permission from the rating services indicated, and do not reflect OSMA's independent evaluation of the companies listed. - Carol Larimer

Selected insurance companies that write medical malpractice insurance coverage in Ohio	NAIC Code	A.M. Best Rating	A.M. Best Dates	S&P Rating	Weiss Rating
American Continental Ins. Co.*	12246	A g	4/21/99	Api	C
American International Insurance Co. **	32220	A++ g	7/6/99	AAA	B
Chicago Insurance Co. *	22810	A+ p	1/25/99	Api	B-
Cincinnati Insurance Co. (The)*	10677	A++ g	6/21/99	AA+	A
Continental Casualty Co., * member of CNA Insurance **	20443	A p	7/6/99	A+	C+
Doctors' Co., an Inter- insurance Exchange (The) * ***	34495	A g	4/26/99	BBBpi	B
Evanston Insurance Co. **	35378	A gu	8/17/99	A+ CreditWatch Negative	C-
Frontier Insurance Co. * ***	34266	A- g	12/28/98	A+	C-
Gulf Insurance Co. *	22217	A+ p	6/8/98	AA	B
Health Care Indemnity Inc. *	35904	A-	4/26/99	BB+pi	C
Kentucky Medical Ins. Co. * ***	38105	A- r	8/31/98	A+	C
Medical Protective Co. * ***	11843	A	4/26/99	AA	B
Medical Inter-Insurance Exchange of NJ * ***	34398	A	2/23/98	BBBpi	C+
Medical Assurance Inc. * *** (formerly Mutual Assurance Inc.)	33391	A g	5/24/99	A+	B
National Union Fire Insur- ance Co. of Pittsburgh, PA **	19445	A++ g	7/6/99	AAA	B+
OHIC Insurance Co. * ***	35602	A-	1/25/99	A	C+
PHICO Insurance Co. * ***	35718	A- g	11/23/98	NR	C
Professionals Advocate Ins. Co.**	29017	A-	4/26/99	BBBpi	C+
ProNational Insurance Co. **	38954	A- g	3/16/98	A-	C

CURRENT GUIDE TO BEST'S RATINGS

March 30, 1998

For a complete explanation of Best's Ratings, please refer to the Preface of *Best's Insurance Reports** or *Best's Key Rating Guide*. Best's Ratings reflect our independent opinion, but are not a warranty of a company's financial strength and ability to meet its obligations to policyholders.

BEST'S RATINGS AND FINANCIAL PERFORMANCE RATINGS (FPR)

A.M. Best assigns to insurance companies one of two types of rating opinions, a Best's Rating (A++ to F) or a Financial Performance Rating (9 to 1). The Best's Rating represents an opinion based on a comprehensive quantitative and qualitative evaluation of a company's financial strength, operating performance and market profile. The FPR represents an opinion based primarily on a quantitative evaluation of a company's financial strength and operating performance. Best's Ratings and FPRs provide an independent opinion of an insurance company's ability to meet its obligations to policyholders. For additional information, refer to the Preface.

Secure Best's Ratings

A++ and A+	Superior
A and A-	Excellent
B++ and B+	Very Good

Vulnerable Best's Ratings

B and B-	Fair
C++ and C+	Marginal
C and C-	Weak
D	Poor
E	Under Regulatory Supervision
F	In Liquidation
S	Rating Suspended

Secure FPR Ratings

FPR 9	Very Strong
FPR 8 and 7	Strong
FPR 6 and 5	Good

Vulnerable FPR Ratings

FPR 4	Fair
FPR 3	Marginal
FPR 2	Weak
FPR 1	Poor

RATING MODIFIERS

Rating Modifiers are assigned to Best's Ratings and Financial Performance Ratings to identify companies whose rating opinions are Under Review (u) and may be subject to near-term change, or are based on a Group (g), Pooling (p) or Reinsurance (r) affiliation with other insurers. For additional information, refer to the Preface.

g - Group

p - Pooled

r - Reinsured

u - Under Review

NOT RATED CATEGORIES (NR)

Companies not assigned a Best's Rating or FPR are assigned to one of five NR categories which identifies the primary reason a rating opinion was not assigned to the company. For additional information, refer to the Preface.

NR-1	Insufficient Data	NR-4	Company Request
NR-2	Insufficient Size and/or Operating Experience	NR-5	Not Formally Followed
NR-3	Rating Procedure Inapplicable		

FINANCIAL SIZE CATEGORIES (FSC)

Assigned to all companies and reflects their size based on their capital, surplus and conditional reserve funds in millions of U.S. dollars, using the scale below. For additional information, refer to the Preface.

FSC I less than 1	FSC V 10 to 25	FSC IX 250 to 500	FSC XIII 1,250 to 1,500
FSC II 1 to 2	FSC VI 25 to 50	FSC X 500 to 750	FSC XIV 1,500 to 2,000
FSC III 2 to 5	FSC VII 50 to 100	FSC XI 750 to 1,000	FSC XV greater than 2,000
FSC IV 5 to 10	FSC VIII 100 to 250	FSC XII 1,000 to 1,250	

How to obtain the latest Best's Ratings

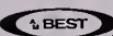
- For the latest Best's Ratings and *Best's Company Reports* (which include Best's Ratings), visit the A.M. Best web site at <http://www.ambest.com>. Requested information can be sent to you by fax or e-mail. Charges are \$4.95 for each Best's Rating or \$19.95 for each Best's Company Report. You may also obtain *Best's Company Reports* by calling our Customer Service department at 908-439-2200, ext. 5742.

To expedite your request, please provide the company's identification number (AMB #).

- All rating actions are published in *Best's Rating Monitor* (our most timely and complete release of ratings). Selected rating changes and new ratings are published in *BestWeek* (our weekly newsletter) and *Best's Review* (our monthly magazine).

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The Insurance Information Source

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Standard & Poor's Insurer Financial Strength Rating Definitions

A Standard & Poor's Insurer Financial Strength Rating is a current opinion of the financial security characteristics of an insurance organization with respect to its ability to pay under its insurance policies and contracts in accordance with their terms. This opinion is not specific to any particular policy or contract, nor does it address the suitability of a particular policy or contract for a specific purpose or purchaser. Furthermore, the opinion does not take into account deductibles, surrender or cancellation penalties, timeliness of payment, nor the likelihood of the use of a defense such as fraud to deny claims. For organizations with cross-border or multinational operations, including those conducted by subsidiaries or branch offices, the ratings do not take into account potential that may exist for foreign exchange restrictions to prevent financial obligations from being met.

Insurer Financial Strength Ratings are based on information furnished by rated organizations or obtained by Standard & Poor's from other sources it considers reliable. Standard & Poor's does not perform an audit in connection with any rating and may on occasion rely on unaudited financial information. Ratings may be changed, suspended, or withdrawn as a result of changes in, or unavailability of such information or based on other circumstances.

Insurer Financial Strength Ratings do not refer to an organization's ability to meet nonpolicy (i.e. debt) obligations. Assignment of ratings to debt issued by insurers or to debt issues that are fully or partially supported by insurance policies, contracts, or guarantees is a separate process from the determination of Insurer Financial Strength Ratings, and follows procedures consistent with issue credit rating definitions and practices. Insurer Financial Strength Ratings are not a recommendation to purchase or discontinue any policy or contract issued by an insurer or to buy, hold, or sell any security issued by an insurer. A rating is not a guaranty of an insurer's financial strength or security.

Insurer Financial Strength Ratings

An insurer rated 'BBB' or higher is regarded as having financial security characteristics that outweigh any vulnerabilities, and is highly likely to have the ability to meet financial commitments.

AAA

An insurer rated 'AAA' has EXTREMELY STRONG financial security characteristics. 'AAA' is the highest Insurer Financial Strength Rating assigned by Standard & Poor's.

AA

An insurer rated 'AA' has VERY STRONG financial security characteristics, differing only slightly from those rated higher.

A

An insurer rated 'A' has STRONG financial security characteristics, but is somewhat more likely to be affected by adverse business conditions than are insurers with higher ratings.

BBB

An insurer rated 'BBB' has GOOD financial security characteristics, but is more likely to be affected by adverse business conditions than are higher rated insurers.

An insurer rated 'BB' or lower is regarded as having vulnerable characteristics that may outweigh its strengths. 'BB' indicates the least degree of vulnerability within the range; 'CC' the highest.

BB

An insurer rated 'BB' has MARGINAL financial security characteristics. Positive attributes exist, but adverse business conditions could lead to insufficient ability to meet financial commitments.

B

An insurer rated 'B' has WEAK financial security characteristics. Adverse business conditions will likely impair its ability to meet financial commitments.

CCC

An insurer rated 'CCC' has VERY WEAK financial security characteristics, and is dependent on favorable business conditions to meet financial commitments.

CC

An insurer rated 'CC' has EXTREMELY WEAK financial security characteristics and is likely not to meet some of its financial commitments.

R

An insurer rated 'R' has experienced a REGULATORY ACTION regarding solvency. The rating does not apply to insurers subject only to nonfinancial actions such as market conduct violations.

NR

An insurer designated 'NR' is NOT RATED, which implies no opinion about the insurer's financial security.

Plus (+) or minus (-) signs following ratings from 'AA' to 'CCC' show relative standing within the major rating categories.

CreditWatch highlights the potential direction of a rating, focusing on identifiable events and short-term trends that cause ratings to be placed under special surveillance by Standard & Poor's. The events may include mergers, recapitalizations, voter referenda, regulatory actions, or anticipated operating developments. Ratings appear on CreditWatch when such an event or a deviation from an expected trend occurs and additional information is needed to evaluate the rating. A listing, however, does not mean a rating change is inevitable, and whenever possible, a range of alternative ratings will be shown. CreditWatch is not intended to include all ratings under review, and rating changes may occur without the ratings having first appeared on CreditWatch. The "positive" designation means that a rating may be raised; "negative" means that a rating may be lowered; "developing" means that a rating may be raised, lowered or affirmed.

'pi' Ratings, denoted with a 'pi' subscript, are Insurer Financial Strength Ratings based on an analysis of published financial information and additional information in the public domain. They do not reflect in-depth meetings with an insurer's management nor do they incorporate material non-public information, and are therefore based on less comprehensive information than ratings without a 'pi' subscript. 'pi' ratings are reviewed annually based on a new year's financial statements, but may be reviewed on an interim basis if a major event that may affect an insurer's financial security occurs. 'pi' ratings are not modified with '+' or '-' designations, nor are they subject to potential CreditWatch listings.

National Scale Ratings, denoted with a prefix such as 'mx' (Mexico) or 'ra' (Argentina), assess an insurer's financial security relative to other insurers in its home market. For more information, refer to the separate definitions for national scale ratings.

Quantitative Ratings, denoted with a 'q' subscript, were discontinued in 1997. The ratings were based solely on quantitative analysis of publicly available financial data.

Federation of Medicine

Benefits and risk of online pharmacies

The following information is from oral testimony AMA Board of Trustee member Herman I. Abramowitz, MD, gave before Congress this summer.

By Herman I. Abramowitz, MD

The AMA is concerned that some prescription drugs are ordered and dispensed over the Internet in a manner that clearly constitutes dangerous medical practice. This raises very serious ethical questions and puts patients at great risk.

Often, Web sites request insufficient data to fill a prescription, and provide limited information about the prescription, including potential risks. Drugs may be provided without a physician consultation, and worse, the prescribing physician may never have obtained or have ready access to a patient's medical history. Further, there is no physical examination or follow up.

There's no verification of the accuracy or truth of a patient's statements electronically, and the physician is not able to use clinical expertise and professional judgment to evaluate the appropriateness of this medication for this patient. Neither is there any discussion of the substantial risks, including death.

In my personal opinion as a practicing physician for more than 30 years, it is vital and in patients' best interests to have a direct, on-site visit with their physicians before taking new or changed medications.

Obviously, there's an urgent need to establish medical safeguards to restrict these dangerous prescribing practices. The AMA has several recommendations:

- 1.) There must be a dialogue between the physician and patient to discuss treatment.
- 2.) The physician should inform a patient about a drug's benefits and risks.



Herman I.
Abramowitz, MD

- 3.) The physician should have appropriate follow-up to assess patient outcome.

What can we do to ensure that safety requirements are met with regard to Internet prescribing practices? The AMA will continue to develop principles for appropriate use of the Internet in prescribing medications, and will coordinate our efforts with other professional organizations. For example, we are working with the National Association of Boards of Pharmacy to develop its Verified Internet Pharmacy Practice Sites program. We also expect to work with state and federal authorities along with state medical societies. States generally have primary jurisdiction over domestic-based Internet prescribing activity, and some states currently are investigating physicians for inadequate online prescribing practices.

The federal government can build on state efforts. The AMA supports the Food and Drug Administration's (FDA) principles governing Internet prescribing. The FDA has an important role to play in prohibiting foreign companies from illegally selling unapproved and approved prescription drugs over the Internet. This practice may permit patients in the U.S. to obtain non-FDA approved drugs without a prescription and/or advice of a physician. This could threaten the whole concept of prescription drugs in the U.S., which would be extremely dangerous to patients. Drugs may be contraindicated, and may react to other medications the patient is taking. The patient may be allergic to a drug, and the risks, including death, are greatly enhanced because there has not been any direct physician/patient relationship. Let me conclude by saying that, as we discuss this fast-changing world of Internet prescribing and telecommunications, please refer to the time-honored oath of Hippocrates taken by your physician and myself. Do no harm. ■

The State Medical Board has finalized rules on Internet prescribing. They are effective Oct. 1.



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From the county files...

Cincinnati task force is studying collective bargaining options

If and when physicians will be able to collectively bargain on contracts, the Cincinnati Academy task force will determine how organized medicine will respond.

The American Medical Association, hoping someday for passage of the Campbell Bill

(H.R. 1304), passed a resolution at its 1999 Annual Meeting to create a collective bargaining unit. That's a more dramatic step than the Academy of Medicine of Cincinnati is prepared to take at this point, says Executive Director Russell Dean. But if and when that step is warranted, the academy plans to be ready. Its newly created collective bargaining task force is looking at what role the academy, alone or in conjunction with the OSMA or the AMA, might play following passage of the bill, which would allow nonemployed physicians to negotiate collectively with health

plans on issues that affect patient care.

The academy's task force has three objectives, Dean says:

1. To develop recommendations for both current and future responses to collective action options such as forming or affiliating with a union;
2. To prepare the academy to respond should Campbell or something like it pass; and
3. To determine how to respond to and become involved with the AMA's private sector initiative, a multi-pronged strategy of pursuing relief from current antitrust laws while also pursuing other permissible advocacy tactics on physicians' behalf.

The task force was created in response to "a rather resounding cry from physicians around the country and locally," Dean says, "that organized medicine needs to do more when it comes to helping physicians do things collectively. It's born of frustra-

tion. It's born of genuine concern that physicians as a profession are losing autonomy. I think it's born of feeling that there are too many other people impacting the relationship between patients and their physicians. And I think it's born of the belief that the pendulum swung too far and there's too much power in the hands of other people."

Dean is concerned that frustrated physicians, feeling as if the ground is crumbling under them, might turn away from organizations such as the academy and the OSMA. They need to stay affiliated, especially now, Dean says. "Now is not the time for physicians to leave decisions that impact their patients and their profession up to those whose interests are not the same."

Dean, task force chair John Larkin, MD, and the 10 other task force members met for the first time in August and will continue to meet regularly until the

group comes up with recommendations to present to the academy council. "It may take two years," Dean says. "It may take six months. But this group is committed to meeting every four to six weeks to take us there. If physicians don't stay together and don't do things collectively or as a part of organized medicine, then important decisions are going to be made by others." — Jan Leibovitz Alloy

Take Action

For more information about forming a collective bargaining task force in your county, call Russell Dean, executive director, Academy of Medicine of Cincinnati, (513) 421-7010.

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Columbus exploring bargaining unit concept

The Columbus Medical Association (CMA) Executive Committee has established a task force to study the issue of collective bargaining for physicians and to consult with members in an effort to decide whether the CMA will develop a collective bargaining unit. The task force will be open to any CMA member and will report its findings back to the executive committee.

"The Columbus Medical Association has always been a forum for an open exchange of ideas and we believe it is very important to gauge the level of interest amongst our physician members regarding the collective bargaining issues," says CMA President Steven Richardson, MD.

At the American Medical Association's (AMA) annual meeting in Chicago, the AMA House of Delegates passed a resolution calling for the es-

tablishment of a mechanism to allow for negotiation between physician employees, including residents who work in public institutions, and their employers. It also calls for the AMA to aggressively pursue repeal of federal antitrust laws, which prohibit self-employed physicians from collectively bargaining with health plans.

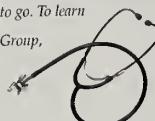
In addition to the task force, the CMA will explore holding a collective bargaining forum this fall. Any CMA member who wishes to join the task force, or express an opinion regarding the collective bargaining issue should contact CMA Interim Chief Operating Officer Diane May at (614) 240-7410.

*(The following information is reprinted with permission from CMA's publication *On Call*)*



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Practice Tips

Which HMOs are riskiest?

A hundred of the country's HMOs have failed to meet minimum capital requirements says a new study by Weiss Ratings, Inc. Nine of them operate in Ohio.

Weiss Ratings, Inc., one of the companies that rates malpractice insurance carriers in *Ohio Medicine*'s quarterly reports (see insert), has turned its attention to rating the financial strength of health maintenance organizations (HMOs) – and its recent study shows the news isn't good.

HMOs suffered a combined \$490 million loss during 1998, with 56% of the companies reporting red ink. Of the 576 HMOs surveyed in the Weiss study, 100 HMOs failed to meet minimum risk-based capital guidelines recently adopted by the National Asso-

ciation of Insurance Commissioners.

What does this mean to you?

"This is not good news for the consumer," says Martin D. Weiss, chair of Weiss Ratings, Inc. "We're bound to see more HMOs dropping Medicare patients, more HMOs going under, and more rate increases as the industry tries to boost profits."

Nor is it good news for physicians, many of whom sign contracts with HMOs that may or may not be on solid financial footing. That's why the OSMA House of Delegates adopted Resolution 26-99 at this year's Annual Meeting. That resolution requires publication of financial data that shows the fiscal strength of all of Ohio's HMOs. (That project is currently under way.) This information, when it becomes available, can be used by physicians to assess their

financial risk before they enter into or continue to maintain a contract with a particular HMO.

Nine Ohio HMOs failing

According to the Weiss study, the heaviest financial losses were incurred by three HMOs that do not operate in Ohio. The three HMOs with the lowest risk-based capital percentages are also not operating in the state. There are, however, nine HMOs licensed to operate in Ohio, that made the Weiss list of 100 failing HMOs. (For a list of the nine, see "Take Action")

Weiss Ratings, Inc., is the nation's only provider of ratings for most HMOs, and the only major rating agency that receives no compensation from the companies it rates. Weiss HMO ratings are based on the compa-

Medicare changes phone numbers

Nationwide Medicare has moved its office from downtown Columbus to Grove City, Ohio. Following is a list of new phone numbers important to Medicare providers.

Provider call center: (614) 277-1199; fax: (614) 277-6805

Electronic medical claims, technical support: (614) 277-6100; fax: (614) 227-6802

Medicare secondary payer: (614) 277-6111; fax: (614) 277-6813

Provider enrollment hot line: (614) 277-6181; fax: (614) 277-6811

Flu/pneumococcal coordinator: (614) 277-6516

There are no changes in Medicare's post office box address. It remains: Nationwide Medicare Operations P.O. Box 182195 Columbus, OH 43218 Medicare's Web site address is: www.nationwide-medicare.com

continued on page 18

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Your Practice Guide

Closing a practice quickly

If a physician's practice must close suddenly because the physician has died or has become incapacitated, the person left in charge has a number of points to consider.

A physician who decides to liquidate his or her practice must follow the proper steps. The physician must, for example, notify patients, cancel registration with the Drug Enforcement Administration, return or dispose of controlled substances, notify insurers, and terminate any retirement plan. (See "In Liquidation, as in practice, patients come first," *Ohio Medicine*, June 1999.) But what if the physician is unable to close the practice? What if, for example, the physician becomes incapacitated? When a practice is closed unexpectedly, the person who takes care of the business has additional points to consider:

- **Legal standing of agent.** "If the practice is worth much money," says Nanci L. Danison, JD, of Dublin, "you would probably want whoever is dissolving it appointed as executor or administrator of the estate, in the situation where the physician has died — or at least have them have the power of attorney, if the physician is still alive and not accessible — so they can handle some of these transactions and also have the legal clout to provide the notices that are necessary."

- **Termination of provider agreements.** Payers must be made aware that accounts receivable are still payable to the practice. If a spouse is trying to unwind the practice after the death of the physician, Danison says, one of the things that needs to be considered is getting out of the lease. The agent might need to change the pay-to address with third-party payors so they send the money to the agent's address. And the agent will want to cancel the account with the physician's billing agency.

- **Termination of all contracts and leases.** The agent will have to take a close look at the provisions of each contract; some include a financial penalty for early termination. What if the practice was only one year into a three-year contract? "You may have to negotiate and explain that the physician is not going to be using their product or their equipment any longer anyway," Danison says. "A lot of it depends on how much you want to negotiate."

If there are security interests in equipment, the agent may simply need to return the equipment. Or, if the residual value of the equipment is less than the amount of the loan still owed, the practice may owe a deficiency. "You have to negotiate with the equipment company," Danison says. "Hopefully they'll let you out of that balance owed."

- **Termination of mortgage and bank loans.** The agent must make sure the bank understands what happened. The bank will want to protect its interests.

- **Sale of assets and dissolution of the corporation.** Any equipment or furniture the practice owned can be sold to pay off debts. But if the practice was incorporated, even if the physician was the only stockholder, he or she would not be entitled to the assets nor, if the physician has died, would the estate. "A lot of physicians don't realize when they incorporate," Danison says, "that most, if not all, of the contracts and assets are in the name of the practice. They think if they go out of business they can just take the assets and use them. It doesn't work that way. If the corporation owns the assets, the corporation will have to be dissolved and then the assets will be distributed to the shareholders or sold to pay corporate debts. The physician doesn't actually get the rights to those assets until they've gone through the corporation."

Usually the agent sells the practice,

adds William Todd, JD, a health care partner with Squire, Sanders & Dempsey in Columbus, and then dissolves the corporation. The purchaser will likely want only the assets, because buying the entire corporation, including the liabilities, might be asking for trouble. "A physician practice management company just paid a \$25 million fine to the federal government," Todd says, "because they had purchased stock of a billing company and then been found to be in violation of certain antifraud provisions and federal statutes." Once the assets are sold, the agent can move toward dissolving the corporation. — *Jan Leibovitz Altay*

Take Action

For more information on how to close a practice quickly, call Nanci L. Danison, JD, (614) 798-1800, or William Todd, JD, health care partner, Squire, Sanders & Dempsey, (614) 365-2712, or contact your attorney.



When you have to deliver bad news

It may be the worst job a physician has — to notify family and friends of a sudden, unexpected death.

For a physician, it may be one of the profession's most stressful duties — having to face family and friends after a patient's sudden, unexpected death, and inform them of the news.

In a new book from Galen Press, *Grave Words: Notifying Survivors about Sudden, Unexpected Death*, author Kenneth V. Iserson, MD, advocates for the use of a protocol for sudden-death notification.

Dr. Iserson gives these suggestions:

- Sit down next to the person you'll be speaking to, if possible.
- Arrange for enough time so that you don't appear rushed.
- Be aware of nonverbal communication and make good eye contact.
- Briefly describe the pre-hospital and hospital events that led up to the death.
- Use the deceased person's name.
- Use clear, nontechnical language.
- If survivors want to speak, listen.
- Do not describe all the injuries in detail, but be willing to answer any questions.
- Use a "D" word, "died," "death," or "dead." Don't resort to euphemisms.
- Do not apologize for the death, since this may make survivors incorrectly think that more could have been done. ■

Take Action

Order a copy of *Grave Words* from the publisher, Galen Press, Ltd., P.O. Box 64400-GW, Tucson, AZ 85728-4400. Phone: (800) 442-5369, Fax: (520) 529-6459. Cost is \$38.95, but Galen Press will offer free shipping if you use the code OHMA when you order.

Didn't I just receive *Ohio Medicine*?

Due to problems at *Ohio Medicine*'s printer, the September issue of *Ohio Medicine* was released for distribution on Sept. 20 instead of the first of the month, as per our usual schedule. The staff of *Ohio Medicine* regrets any inconvenience this scheduling delay may have caused.

Risky HMOs

Continued from page 16

ny's own internally-developed risk-based capital standards for evaluating HMO solvency. Weiss also analyzes a company's five-year historical profitability, liquidity, and stability, which includes asset and premium growth, strength of affiliate companies, and risk diversification. ■

Take Action

If you are interested in obtaining a list of the nine HMOs licensed in Ohio that failed to meet the new NAIC minimum capital guidelines as reported by Weiss Ratings, Inc., contact the *Ohio Medicine* reader response line, (800) 766-6762, Ext. 6580, for a copy. Ask for Item #25-99.

Point-of-service

Continued from page 8

islators and key public policymakers support the concept of point-of-service. The compromise was to examine what is happening in the marketplace, and then tailor a legislative solution if necessary."

The task force is comprised of OSMA members John Davren, MD, Cincinnati and Ed Bope, MD, Columbus; Sen. Louis W. Blessing (R-Cincinnati), Sen. Grace L. Drake (R-Solon), Sen. Robert F. Hagan (D-Youngstown), Rep. J. Donald Mottley (R-West Carrollton and sponsor of Sub. HB 16), Rep. Betty Sutton (D-Barberton), and Rep. Dale N. Van Vyven (R-Sharonville). Additionally, the committee will include the Superintendent of Insurance, two health insuring corporation (HIC) representatives – both authorized to operate in Ohio with one of them offering a point-of-service plan; two consumers and two employers – one with over 25 employees and one with less than 25 employees.

In the remaining months of 1999 the task force will identify market trends and gather data. "Our goal with this task force is to gain a better understanding of what is happening today in Ohio's health insurance marketplace," says Lashutka. — Yvonne Bury



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Your Practice Guide

Coalition draws together managed care and physicians

The Columbus Health Department hopes its new medical directors coalition will facilitate discussions between managed-care plans and physicians – and improve the community's health in the bargain.

The Central Ohio Medical Directors Coalition is on a mission: To create universally acceptable managed-care treatment and coverage guidelines for physicians. "It will make their lives easier," says Teresa Long, MD, medical director of the Columbus Health Department and spokesperson of the nine-month old coalition.

The group, which formed under the leadership of the Columbus Health Department, is composed of medical directors of local managed-care organizations, as well as representatives from large physician groups and physician-hospital organizations. An invitation to join remains open to all area managed-care organizations. Some major insurers already members are:

- United Healthcare;
- Anthem Blue Cross and Blue

Shield;
• Prudential
Healthcare (a member company of Aetna U.S. Healthcare);
• Nationwide

Health Plans, Inc.;
• Aetna U.S. Healthcare; and
• OSU Managed Health Care Systems, Inc. Combined, these insurers cover more than half of Franklin County's one-plus million residents.

"This (coalition) initiative is one of the department's community partnerships," says Dr. Long. "Its purpose is to promote preventive health practices and health promotion activities."

The coalition's first activity is to create a unified set of guidelines for breast and cervical cancer screenings, then to communicate this new information well and often to physicians. "It's a four-way win," says Dr. Long. "Health plans, their physician-partners, employers and employee-members and their families all have interests in improving their personal health and our overall community health status."

The Columbus Health Department,



Teresa Long, MD

which represents the interests of all four groups, provides the neutral ground on which discussions can take place and grow. "We believe that doctors speaking to doctors through this type of vehicle can have a huge impact in this community," says Dr. Long.

More sensitive subjects, such as fee schedules and reimbursement rates, will not be brought to the table by coalition members. That, says Dr. Long, will avoid any suggestion of collusion. "However, we do expect to share ideas and communication channels so that we may more effectively address community health issues and reach most of the physicians in central Ohio," she says.

Other coalition initiatives may include tobacco-use cessation, asthma assessment and treatment, and childhood and adult immunizations.

Dr. Long sums up the coalition's purpose this way: "The whole community can benefit from a focused synergy between the local managed-care organizations and their physician partners." — Carol Larimer

OSMA material can benefit your practice

The OSMA continues to produce a variety of materials for the benefit of its members. All of the following items are still available. If you've missed an item and wish to receive it, mark the appropriate space(s) below and mail this form to: *Ohio Medicine*, 3401 Mill Run Rd., Hilliard, OH 43026, or fax to *Ohio Medicine*, (614) 527-6763. Or you can order these materials online by going to the OSMA Web site (www.osma.org) then go to "Membership Information" and click on "OSMA Store".

Pain – The Fifth Vital Sign.
Information on prescribing for patients with chronic benign pain. Offers up to two hours Category 1 CME. Free to members; \$20 for nonmembers

Standardized Credentialing Disk.
HMOs are now required to accept a state-developed standard credentialing form. The OSMA has placed this standard form on disk. Free to members; \$25 for nonmembers.

Y2K Readiness Guide
Will your practice be ready when the calendar turns to Jan. 1, 2000? A handbook of steps to take now to prepare, as well as Ohio-specific contacts you can call if you have problems. Free to members; \$20 for nonmembers.

Osteoporosis information for physicians
This handbook, which launched the OSMA's Women's Health Initiative project, contains Ohio-specific data, as well as more general information. It offers up to two hours Category 1 CME. Free to members; \$20 for nonmembers. ■

How clear are you on the new DNR orders?

The state's new standardized "Comfort Care" orders may be still creating confusion – but the OSMA can help.

Did you just sign a do-not-resuscitate order for a healthy patient? It could happen. Since the state's new, standardized do-not-resuscitate (DNR) orders took effect May 20, there is still some confusion surrounding who the orders are for, who writes them, when they are ac-

vated, and how they are documented.

Since the "Comfort Care" and "Comfort Care-Arrest" forms (the two types of DNR orders) are available on the Ohio Department of Health's (ODH) Web – along with wallet identification and bracelet inserts – it's entirely possible for one of your healthy patients to download the ODH form and/or identification and bring it to your office for a signature. DNR orders, of course, are meant for dying patients.

If you're confused about the state's new, standardized do-not-resuscitate

orders, the OSMA can help. The association has assembled a DNR informational packet that includes sample order forms, protocols, information sheets for physicians, as well as material about the new DNR form that you can share with your patients.

Packets have been sent to all who have pre-ordered them. If you did not place a pre-order, but would like to receive a packet, contact the *Ohio Medicine* reader response line (800) 766-6762, Ext. 6580, and ask for Item #22-99. ■

Your Practice Guide

Third-party update...

News from private and government payers

HCFCA 1500, crossover claims must be mailed to new address...All Medicaid claims HCFCA 1500 and non-Medicare/Medicaid crossover hard copy claims should be mailed to: Ohio Department of Human Services, P.O. Box 7965, Akron, OH 44306, effective immediately. Do not mail any Medicaid claims to the old address, P.O. Box 2644, or the claims will be returned to sender. (Medicare has changed its phone numbers. See item on page 16.)

Summa introduces one-call transport line...Summa's recent pairing with Cleveland Metro Life Flight has resulted in Summa's One-Call Transport Line, a special line that provides referring physicians quick access to Summa's trauma services. The goal, Summa explains, is

to provide immediate access to its Level I trauma and emergency care, making it easy for referring physicians to get transportation and admission for their critical care patients. When an admitting physician makes a call, a transport coordinator immediately begins to arrange for an air or ground ambulance, admission at Summa by an emergency department physician or specialist, and any other requirements requested. The Transport Line phone number is (800) 771-8181.

United Healthcare requires lab requisition forms... All requests for SmithKline Beecham laboratory services for United Healthcare members must be submitted on the lab's testing requisition form. The forms are pre-printed with

your account number and requisition numbers. When completing the form, note:

- The member name on the requisition form must match the name in the United Healthcare's eligibility file.
- If physician orders are illegible or include only nonspecific test panel names without accompanying test codes, (i.e. "Chem Panel," "SMAC," "Prenatal Profile," etc.), SmithKline Beecham will have to call the physician to clarify the order. By using specific test codes on the form, SmithKline Beecham will bill only for the exact tests ordered.
- That all medically inappropriate diagnosis codes and specific diagnosis information should be provided, so disease management programs can be developed and/or used if appropriate.

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Ohio Medicine (ISSN 0892-2454/USPS 405-200) is published monthly for a yearly subscription by the Ohio State Medical Association, 3401 Mill Run Drive, Hilliard, Ohio 43026. Periodicals postage paid at Hilliard, Ohio and at additional mailing offices. POSTMASTER: Please send address changes to *Ohio Medicine*, 3401 Mill Run Drive, Hilliard, Ohio 43026.

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Immunization codes

The story "New immunization codes likely to create confusion" which ran in the August 1999 issue of *Ohio Medicine* ran with two incorrect codes. The codes 90741 and 90742 should have run as 90471 and 90472. *Ohio Medicine* regrets the error.

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Focused Task Forces

continued from page 12

House policy calls for retaining the two standing committees established by OSMA Bylaws (Judicial and Professional Relations and Auditing and Appropriations). I have already assigned members to participate through 1999-2000 on these two committees as well as the following FTFs:

- State Legislation;
- Accreditation;
- Education; and
- Sports Medicine.

But there are plenty of opportunities for you to participate on other FTFs. I have identified 17 broad issues that the OSMA is likely to address in the coming year. By now, you should have received a mailing from me that allows you to indicate your interest in these topics. It's from this list that future FTF members will be drawn. If you haven't received the information, an invitation to participate on a focused task force is included in this issue of *Ohio Medicine* (see page 12). You may also visit the OSMA Web site, www.osma.org, to complete an application. See "news roundup" under "hot news."

I hope you'll consider serving as a member of one of these very important groups. Often your input can be gathered by fax or e-mail, and many meetings will be held by conference call so you won't have to travel. Your commitment may only be one to three months instead of years, as was typical of many OSMA committees.

FTFs will enable the OSMA policies and programs to be more representative of its membership because it will be hearing from more of you more often. But here's where you come in. We want and need to hear from you. We're listening, but you have to be willing to talk.

Begin by indicating your interest in one of the topics we've named — and volunteer if you're asked to serve on a focused task force. Share with us your expertise and ideas. In order for the OSMA to be effective in the new millennium, we need members who are willing to actively participate in the workings of organized medicine. We'll try to make that participation as easy and friendly as possible.

So complete the form and send it in. I'll look forward to hearing from you. ■

Colleagues

Newsmakers

I. LEONARD BERNSTEIN, MD, Cincinnati, was presented with the 1999 Daniel Drake Award during an Honors Day Program at the University of Cincinnati's College of Medicine. The award is the medical school's highest honor and is given to distinguished living faculty or alumni making outstanding contributions to medical education, scholarship or research and commemorates the college's founder, Daniel Drake.

GARY BIRNBAUM, MD, JD, FCLM, Mayfield Heights, has been appointed adjunct professor of law at the Case Western University School of Law. Dr. Birnbaum received his law degree, Magna Cum Laude, from Cleveland Marshall College of Law in

1991. He is a Fellow of the American College of Legal Medicine and presently is in general practice in Mayfield Heights.

JOHN B. COLEMAN, MD, Toledo, has been named the 1999 Family Physician of the Year by the Ohio Academy of Family Physicians (OAFP) for exemplifying the highest standards of professional and community service. Candidates must be an outstanding family physician role model; provide high-quality, family-centered, continuing health care; be active in the community; currently practicing; and be an OAFP member with at least 10 years post-residency experience.

WILLIAM GERHARDT, MD, Cincinnati, was honored as 1999 Distinguished Alumni by the University of Cincinnati College of Medicine for his outstanding

leadership and contributions to the field of medicine. Dr. Gerhardt, who earned his medical degree from UC in 1954, practiced pediatrics in Western Hills for more than 38 years.

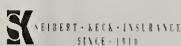
JAMES GARFIELD, MD, Cincinnati, has been named senior medical director for the Southwest United Healthcare of Ohio.

KEVIN J. GRANNAN, MD, Cincinnati, recently received a three-year appointment as Cancer Liaison Physician for the Hospital Cancer Program at Good Samaritan Hospital. The Cancer Liaison Program is an integral part of the Commission on Cancer of the American College of Surgeons.

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Obituaries

RICHARD S. BORNSTEIN, MD, Beachwood, OH, Ohio State University College of Medicine, Columbus, OH, 1964; age 60; died Aug. 18, 1999.

AARON SIMON CANOWITZ, MD, Columbus, OH, Ohio State University College of Medicine, Columbus, OH, 1929; age 91; died July 12, 1999.

LOUIS D. CHAPIN, MD, Cleveland, Case Western Reserve University, School of Medicine, Cleveland, 1937; age 87; died Aug. 2, 1999.

WALTER K. CHESS, MD, New Concord, OH, Case Western Reserve, School of Medicine, Cleveland, 1946; age 77; died July 31, 1999.

OSCAR W. CLARKE, MD, Galipolis, OH, Medical College of Virginia Commonwealth University, School of Medicine, Richmond, VA, 1944; age 80; died Aug. 16, 1999.

ROGER E. HEERING, MD, Columbus, OH, University of Michigan Medical School, Ann Arbor, MI, 1933; age 89; died July 17, 1999.

HOWARD C. KINGSBERRY, MD, Lima, OH, University of Illinois at Chicago Health Sciences Center, Chicago, 1943; age 82; died July 30, 1999.

LOUIS G. MARTIN, MD, Toledo, Case Western Reserve University, School of Medicine, Cleveland, 1949; age 76; died Aug. 2, 1999.

FRANK L. MEANY, MD, FACS, Cleveland, St. Louis University, School of Medicine, St. Louis, 1938; age 87; died Aug. 31, 1999.

JOHN M. STRAIT, MD, FACS, Middletown, OH, Ohio State University, College of Medicine, Columbus, OH, 1941; age 81; died July 25, 1999.

LOUISE SIU CHING WU, MD, Elyria, OH, Hackett Medical College for Women, Canton, Kwangtung, (Extinct), China, 1934; age 90; Aug. 12, 1999.

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Ohio Medicine

3

The U.S. House passed the Norwood-Dingell bill, an AMA and OSMA-supported federal patients' rights bill that allows patients increased access to physicians and a right to sue their HMOs for adverse outcomes caused by bad medical decisions.



4

The year 2000 races will be interesting for medicine, especially the Supreme Court races. But term limits mean that the state races are also more important than ever.



10

OSMA's new breast cancer book focuses on communications and information routing. A book written by doctors... or doctors.



16

Should you earn an MBA? More physicians are learning that they must understand business, and the business community, if they are to influence it.

11

Compt-pay data has been collected by the OSMA, and will be studied to determine the best way to address this major professional concern.

Three new laws may impact your practice

Laws on asthma inhalers for schoolchildren, handicap parking stickers and direct access to ob-gyns (under the patients' rights law) are in effect. Here's how they work.

Three new laws affecting physician practices are now in effect. Two took effect last month, a third law becomes effective Nov. 3. Here's a quick review of the laws and the impact they are likely to have on your practice.

Asthma inhaler law (HB 121)

Ohio schoolchildren may now carry



Handicap parking placard law takes effect. To authorize a handicap parking placard for patients, physicians must now write a prescription for the placard. And penalties now exist for physicians if they knowingly prescribe the placard for a longer period than necessary.

asthma inhalers with them and use them at school. Previously, many schools required that asthma inhalers

be stored in the school office. The OSMA was a strong supporter of the legislation, which becomes effective Nov. 3. Under the new law, physicians and parents must sign permission forms that allow the child to carry the inhaler. Copies of the permission form must be provided to the principal and the school nurse if one is assigned to the child's building. OSMA members may obtain a free copy of the inhaler permission form to photocopy for office use. The form has been prepared by the Ohio Association of School Nurses, and includes the minimum information required by the law. For more information about this form, and

Continued on page 9

OSMA monitors HealthFirst sale

The sale of HealthFirst, a Marion, Ohio-based HMO, to Medical Mutual of Ohio, has left a number of Ohio physicians seeking information about the sale, including how payment of outstanding claims will be handled, and how to obtain prior or authorization for treatment.

The OSMA Department of Ombudsman Services has been in contact with both Medical Mutual and HealthFirst, and is monitoring this situation closely. The association sent information to members about the sale as soon as it became available, and links were established from the OSMA Web site to Medical Mutual's Web site for those who prefer electronic communications.

What you should know about the sale:

- While regulatory approval of the sale is pending, \$1,550,000 in provider payments will be held, but claims are being processed on a daily basis. Any commercial claims you have for services provided before Aug. 31, should have been forwarded to HealthFirst offices prior to Sept. 30. Medical Mutual will

advise your office of how to submit claims for services provided with a service date of Sept. 1 or beyond.

- HealthFirst member benefits will continue according to their current coverage. HealthFirst members can continue to use their HealthFirst cards until they receive new ones from MMO. Current eligibility can be verified by calling (800) 362-1279.

- Provider relationships and existing specialist referrals will remain in place as previously approved by HealthFirst's staff. Referrals for specialty care after Sept. 1 can be made via the normal Marco system process for MMO network

providers, or by calling (800) 258-2873.

- The transaction involves commercial enrollees only. Medicare members, whether enrolled through HealthFirst's direct program or through groups, will maintain their HealthFirst benefits for up to a 60-day period. That will enable them to review information about other health-care programs available to them. The Health Care Financing Administration will be monitoring care during this period, so providers are urged to continue to provide quality benefits and service to members.

• Medicare members can only be held

Continued on page 3



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Bills, Laws & Rules

Federal legislation

U.S. House OKs Dingell-Norwood bill

Patients may be able to sue HMOs if bill passes a Senate-House conference committee.

The American health-care system may be closer to significant managed-care reform. Last month, the U.S. House of Representatives passed the Dingell-Norwood patients' rights bill, a measure that has been supported by organized medicine, including both the AMA and the OSMA.

The bill, crafted by Rep. John Dingell (D-Mich.) and two physicians, Rep. Charlie Norwood (R-Ga.) and Rep. Greg Ganske (R-Iowa), allows patients increased access and a right to sue their HMO for adverse outcomes based on a plan's decision to delay or block payment for treatment – essentially repealing the current federal ban on lawsuits against insurance and managed-care companies.

In addition, this bill requires plans to pay for "reasonable" care delivered in emergency department settings, and gives patients direct access to obstetricians-gynecologists. An OSMA-supported Patient Protection Act with similar provisions passed the Ohio Legislature earlier this year.

Although a number of alternative managed-care reform measures were considered during the House debate, all were defeated in favor of the Dingell-Norwood bill.

The following Ohio congressional representatives supported the legislation:

- Rep. Steven C. LaTourette (R-Painesville)
- Rep. Sherrod Brown (D-Elyria)
- Rep. Tony P. Hall (D-Dayton)
- Rep. Stephanie Tubbs Jones (D-Shaker Heights)
- Rep. Dennis J. Kucinich (D-Lakewood)



- Rep. Tom Sawyer (D-Akron)
- Rep. Ted Strickland (D-Portsmouth)
- James A. Traficant, Jr. (D-Youngstown)

The following U.S. representatives opposed the Dingell-Norwood bill:

- Rep. John A. Boehner (R-Hamilton)
- Rep. Steve Chabot (R-Cincinnati)
- Rep. Paul E. Gillmor (R-Port Clinton)
- Rep. David L. Hobson (R-Springfield)
- Rep. John R. Kasich (R-Columbus)
- Rep. Bob Ney (R-Bellaire)
- Rep. Michael G. Oxley (R-Findlay)
- Rep. Deborah Pryce (R-Columbus)
- Rep. Ralph Regula (R-Canton)

Rep. Marcy Kaptur (D-Toledo) and Rep. Rob Portman (R-Cincinnati) were not available to vote.

In news reports following passage of the bill, Rep. Ted Strickland (D-Lucasville) was quoted as saying: "This Congress, right now, has an historic opportunity to take medical decisions out of the hands of insurance bureaucrats and put them back in the hands of patients and physicians. America's families have spoken loud and clear. They want the right to see their own doctor. They want to be able to see a specialist without having to jump through bureaucratic hoops. They want the right to seek justice in a court of law if an insurance company makes a medical decision that hurts them or a loved one. Most of all, they want to make sure that they and their doctors are making medical decisions, not in-

surance bureaucrats."

At press time, the bill was in a House-Senate conference committee. The committee will try to merge the House measure with a bill that passed the Senate in July. The Senate bill offers faster access to specialists, but does not allow patients the right to sue health plans. *Ohio Medicine* will continue to follow the debate and bring you developments as they occur. ■

HealthFirst sale

Continued from page 1

responsible for the costs of normal copayments, deductibles, or noncovered services. Also, scheduling delays will be the sole responsibility of the involved provider.

Providers who are not currently part of MMO's networks will be given the opportunity to contract with MMO, contingent upon successful completion of credentialing. ■

Take Action

If your office experiences problems with either HealthFirst or Medical Mutual on claims and other administrative issues over the next month, you're encouraged to contact the OSMA Ombudsman staff for assistance. In addition to trying to resolve your issue with the company, they will also alert the Ohio Department of Insurance of any major problems that may be occurring. For a link to the MMO Web site, visit the "Links" section of the OSMA Web site, www.osma.org, or go to www.mmmh.com.

U.S. health-care bills

Other federal health-care measures include:

Training in children's hospitals

A House bill proposing \$565 million over two years to reimburse children's hospitals for training medical residents passed the House recently, and must now be reconciled with a bill that passed the Senate earlier this year. Both bills provide "quick fixes" to a growing problem. The Senate bill would extend payment over four years.

Preventing assisted suicide

The House Judiciary Committee approved the Pain Relief Promotion Act which would clarify that doctors and other providers would not face criminal charges if a patient dies from controlled substances prescribed to relieve pain. The bill also clears the way for the Drug Enforcement Administration to take action, such as pulling a physician's DEA license, in those cases where lethal doses are prescribed to aid a suicide. If passed, the federal bill would void Oregon's assisted-suicide law.

Protecting patient privacy

If Congress fails to pass legislation that protects the confidentiality of electronically transferred medical information by Feb. 21, 2000, the U.S. Department of Health and Human Services will step in to issue regulations on the subject. Congress has already failed to meet one self-imposed deadline for passing a law, but vows it will act before the end of the year. One sticking point preventing action: Can individuals sue when their privacy rights are violated? The bill does include civil and criminal penalties for entities that breach confidentiality rules.

Competition in Medicare?

A U.S. House Ways and Means subcommittee member is attempting to reform Medicare by bringing in more competition. Rep. William Thomas (R-California) who chairs the subcommittee, favors a plan that integrates marketplace innovations with Medicare as a way to control costs. The model under review would reward seniors for choosing low-cost, efficient plans, and allow them to choose plans that best serve their needs.

Why the year 2000 races are important for medicine

The Supreme Court race may be the most significant one for medicine, but term limits in the Legislature will make those elections interesting as well.

It's not too early to begin thinking about the 2000 elections. Your vote is important to organized medicine, and to your patients, but first you need to decide *who* is the best person for the job. The presidential race is likely to steal much of the spotlight next year, but you should know that there are a number of important state races taking place as well.

One of the most pivotal races for medicine will be the Supreme Court races, now that the tort-reform issue is back on the drawing board, so to speak. Among the seven members of the Ohio Supreme Court, two seats are up for grabs in the 2000 elections. "Four court members are of a different mind-set and philosophy than medicine's usual viewpoint," says Tim Maglione, OSMA director of Legislation. So with Justices Deborah L. Cook, a Constitutional-interpretation conservative and Alice Robie Resnick, a more liberal activist, up for re-election, a chance to change the court can become a reality. No candidate has announced to run against Justice Cook. As for the Resnick seat, State Senator Bob Cupp (R-Lima) is seriously considering a run for the high court.

"Organized medicine and certainly our PAC's intention is to identify candidates for the high court who truly understand the separation of powers and don't legislate from the bench," says Maglione. In the present court, he continues, the majority of justices have become law makers rather than law interpreters, robbing the General Assembly of its responsibility to create laws. Maglione describes the current court's alliance in law-making as more philosophical than "power play," but such behavior still violates the principle of separation of the three branches of government.

"As candidates announce for the Supreme Court, we need to evaluate them by: 1) Are they respectful of the separation of powers? 2) Do they intend to respect and defer to the legislative branch on policy matters? And



House speaker pro tempore
Randy Gardner...could swap
seats with Sen. Bob Latta.



Rep. Pat Tiberi...running for U.S.
Rep. John Kasich's seat.

most importantly – 3) Do they understand organized medicine?" Maglione adds.

As the 2000 campaign season gets under way, the OSMA's Ohio Medical Political Action Committee (OMPAC) will be very involved in identifying candidates and making sure they meet the three-part test before supporting them, Maglione says. "OMPAC would also support Justice Cook's re-election and would likely support Sen. Cupp's run against Justice Resnick. By re-electing Justice Cook and replacing Justice Resnick with Bob Cupp, the court's majority would shift to a more judicially restrained, conservative branch. That would be good for Ohio."

In other races

Term limits are changing the character of the Ohio General Assembly. Here's how:

- Many of the long-time legislators who understood medical issues have been forced to move to other roles.
- Among the candidates who are existing legislators and not yet subject to term limits, many will have less than one year's experience by the time they announce for the 2000 elections.

"What this means," says Krista Bisline, OSMA political coordinator, "is that, each session, the OSMA and organized medicine in general has to go through a process of re-educating legislators on vital health-care issues. And each time, you're dealing with an unknown factor. You don't know whether this legislator will be a friend of med-

John Kasich's seat in District 12.

"Critics might say such contests (for seats in the General Assembly) violate the spirit of term limits, but I disagree," says Maglione. "You can't build an empire in one branch of the Legislature. If people don't like you, they will vote against you. The ballot box is the way to deal with candidates that should or should not be elected."

As the 2000 elections draw closer, look to the OSMA, its publications and Web site, to keep you informed of all the races. — Yvonne H. Bury

Toke Action

One way to make your voice heard is to vote, of course. Another is to contribute to the Ohio Medical Political Action Committee, or OMPAC. For more information about OMPAC and how to contribute, contact Krista Bisline, OSMA Department of Legislation, (800) 766-6762, Ext. 6748.

icine or not."

Representatives likely to face off for Senate seats in the General Assembly include:

- Rep. Steve Austria and Rep. Joe Haines for Sen. Merle Kearns's seat in District 10.
- Rep. Jim Buchy and Rep. Jim Jordan for Sen. Bob Cupp's seat in District 12.
- Rep. Priscilla Mead and Rep. Bill Schuck for Sen. Gene Watts's seat in District 16.
- Rep. Ron Amstutz and Randy Jotte, MD, for Sen. Grace Drake's seat in District 22.
- Rep. Randy Gardner for Sen. Bob Latta's seat in District 2.
- Rep. Jeff Jacobson for Sen. Charles Horn's seat in District 6.

Senators running for House seats will likely include:

- Sen. Anthony Latell, running for Rep. June Lucas Ferderber's seat in District 67.
- Sen. Merle Kearns, running for Rep. Steve Austria's seat in District 76.
- Sen. Bob Latta, running for Rep. Randy Gardner's seat in District 4.

One way legislators are finding ways to continue public service in the era of term limits is to swap seats – from House to Senate and vice versa. House Speaker Pro Tempore Randy Gardner (R-Bowling Green) and Sen. Bob Latta (R-2nd) could be swapping seats, as could Rep. Steve Austria (R-Beavercreek) and Sen. Merle Kearns (R-16th).

On the national level, Rep. Pat Tiberi (R-Columbus) and Sen. Gene Watts (R-16th) are vying for U.S. Rep.

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Medical board report Rule issued on Internet prescribing

No controlled substances or dangerous drug may be prescribed, dispensed or provided to a patient the physician has never personally examined or diagnosed.

The State Medical Board of Ohio has developed a rule that will provide some safeguards against Internet prescribing. Effective Oct. 1, the new rule states that a physician cannot prescribe, dispense or otherwise provide any controlled substances or dangerous drugs to a person the physician has never personally examined physically and diagnosed.

There are exceptions, however. Drugs may be provided by others to patients who are admitted or are residents of an institutional facility. Drugs may also be provided to patients in the following situations:

- A physician may provide drugs to a colleague's patient, if the drugs are provided pursuant to an on-call or cross-coverage arrangement between the physicians.
- A physician may provide drugs to a person who the physician has accepted as a patient, and has scheduled for a physical exam, but who has not yet examined the patient. The drugs are intended to be used pending that appointment.
- Emergency medical squad personnel, nurses or the appropriately trained and licensed individuals may provide drugs to a patient, in accordance with protocols approved by the State Board of Pharmacy.
- A nurse may provide drugs to a patient in accordance with a standard care arrangement that meets the requirements of the revised code and rules promulgated by the board of nursing. ■

Take Action

If you have any questions about the medical board's new rule and/or its exceptions, contact Nancy Gillette, JD, OSMA Division of Legal Affairs, (800) 766-6762, Ext. 6767, e-mail: gillette@osmo.org.

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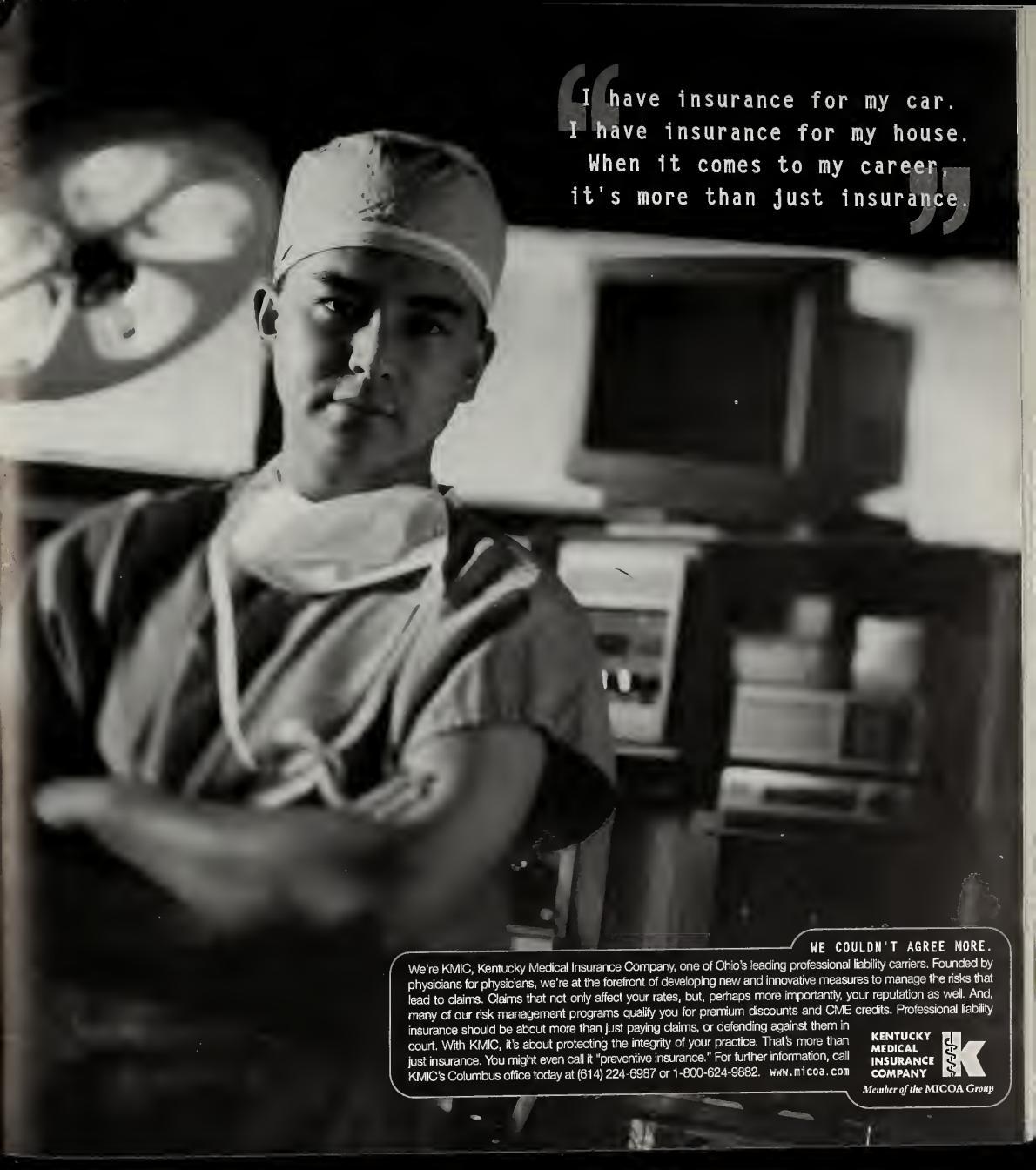
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House Concurrent Resolution 36, Healthier babies

If passed, HCR 36 would designate October as Healthier Babies month, and the first week in October as Healthier Women-Healthier Babies Week.

Sponsor: Rep. Amy Salerno (R-Columbus)

OSMA position: Not considered.

House Bill 428, Drug schedule

This bill would make gamma-hydroxybutyrate a schedule II controlled substance and revises the state controlled substances schedules according to the federal drug laws.

Sponsor: Rep. Chuck Calvert (R-Medina)

OSMA position: Support

House Bill 444, Medicaid expansion

HB 444 would expand the Medicaid program to employed, residential parents of children under age 19, with family incomes not exceeding 150% of the federal poverty guidelines.

Sponsor: Rep. Catherine Barrett (D-Cincinnati)

OSMA position: Not considered

Senate Bill 183, Needle safety

This bill would require each public employer who employs public health-care workers to develop an exposure control plan, incorporating the use of needle-less systems, and sharps with injury protection devices. The bill is meant to reduce the risk of these workers, who are subject to 20 blood-borne diseases, including hepatitis and HIV if they are unintentionally stuck by a needle. The needles cost 25 cents to 50 cents more than standard needles, but the bill's supporters say that's a small price to pay compared to the cost of treating a patient suffering from AIDS.

Sponsor: Sen. Dan Brady (D-Cleveland)

OSMA position: Under advisement.

Garbage medicine

To the Editor:

I was impressed with Dr. Kenneth D. Christman's letter to the editor in the August issue of *Ohio Medicine* ("Alternative medicine in curricula is shocking").

Certainly, he produced an extraordinary review in a matter of a few paragraphs of this tragic development, not only within the framework of the medical school curricula, but also as far as medical practice in general is concerned. But when one realizes that literally billions of dollars are spent on this alternate form of health care, it becomes even more disturbing.

Like many American physicians, I have spent time in China, and had opportunities to review not only acupuncture anesthesia, herbal medicine, and traditional medicine that is taught in their medical schools, but also I consider myself a good friend of C. Norman Sheeley, MD, who Dr. Christman mentioned at least twice in his letter.

I can't share Dr. Christman's opinions that a great deal of this work has been shown to have statistical significance and perhaps has been therapeutically effective in various ways. The truth of the matter is that this whole world of alternative medicine is at variance with the basic scientific principals upon which modern-day medicine is based and practiced. One can only wonder how the poor medical student today can absorb all of the wonderful



letters

advances and do interpretations of physiology and biochemistry, particularly in the areas of molecular biology and at the same time, have to study these ridiculous forms of medical practice. Yes, of course they've been in place for millions of years, but that is hardly proof that they are appropriate. It's more an indication that they are of no value. Please remember with all of this, the patient must be taught that if they are "self-therapizing" themselves, they must inform their physicians of the various herbal preparations that they are taking so that such self-medication will not conflict with their prescribed medications.

Thank you, Dr. Christman, for a wonderful review of what I consider garbage medicine.

Robert J. White, MD
Cleveland

Insurer says it's Y2K ready

To the Editor:

I would like to respond to an article in your July 1999 edition, entitled "Are insurers prepared for Y2K?" The article quoted Martin Weiss, chair of Weiss Ratings, Inc., who expressed his concern that most insurance companies are not prepared for Y2K. He points to the results from a survey that Weiss conducted in December 1998. He voiced his greatest concern over the groups that did not respond to the survey, stating that he expects that they are even more likely to be behind schedule than the group that answered the survey.

While we at Kentucky Medical Insurance Company commend the effort of Weiss to measure the Y2K preparedness of insurance companies, we are concerned about raising a false alarm over this subject. While I can't speak for the entire insurance industry, I can tell you what we are doing at our company.

We estimate at KMIC and our parent organization, Mutual Insurance Corporation of America, that we have received more than 100 questionnaires in the past year on our Y2K preparedness from various organizations. Our Y2K coordinator tries to answer as many of these as possible, but it is impossible to answer them all. We did answer the Weiss survey last December, and recently completed a fol-

low-up survey. To our astonishment, though, Weiss assigned a low rating to KMIC for Y2K preparedness. They will not discuss their rating criteria, so we remain in the dark about our rating.

We now have completed all mainframe system application testing for the upcoming change of century. Following months of preparation, our programmers have spent several weekends this year turning forward the computer clocks, and running the critical programs as though the century had changed. We consider our testing complete. We are using the remaining time to double-check off-the-shelf PC applications, such as Word for Windows, Excel, etc.

We want to assure Ohio physicians they can be confident that KMIC is prepared to face the change of century with minimal disruption in service. We are prepared for the rollover on Dec. 31, 1999, and urge your readers not to react to the naysayers who gain attention by predictions of disaster. Anyone wanting more information about KMIC's Y2K preparedness can visit our Web site at www.micoa.com or call me at (800) 624-9882.

Don Green

Vice President, Ohio Marketing
Kentucky Medical Insurance Company

Three new laws

Continued from page 1

how to obtain a copy, see the story on page 20.

Handicap parking placard law (HB 148)

This new law, which became effective Oct. 14, changes the way physicians authorize handicap parking placards for patients. Instead of merely signing a form, you now must write a prescription for a handicap placard, verifying that the patient meets at least one of the criteria for obtaining a placard recognized in the law. These basically cover patients who have health conditions that limit their ability

to walk. Physicians who improperly prescribe handicap placards for patients not meeting the criteria or physicians who knowingly prescribe the placard for a longer period of time than necessary, will be guilty of a misdemeanor of the first degree. The OSMA strongly opposed the penalty portion of the legislation, but was unable to have it dropped from the final bill. If you would like a free copy of the fact sheet on this new law, and you are an OSMA member, contact the *Ohio Medicine* reader response line, (800) 766-6762, Ext. 6580, and ask for Item #32-99.

Direct access to ob-gyns (HB 4)

This provision of HB 4, the Governor's Patient Protection Act, will permit Ohio women to have direct access to the obstetrician/gynecologist of their choice within their health plan without obtaining a referral from their primary care physician. It became effective Oct. 13. The remainder of the law, which includes an external review provision allowing for an independent review of medical necessity denials, doesn't become effective until May 1, 2000. There is some uncertainty regarding

how the new law will be implemented. The OSMA is currently contacting health plans and the Ohio Department of Insurance to gather information on this issue. To help it gauge insurer response to the law, the OSMA is asking that ob-gyns who currently participate in plans that limit access to their services contact the OSMA Ombudsman staff at (800) 766-6762, Ext. 6759 if they experience problems with the direct access provision. ■

OSMA News

Women's Health Initiative



OSMA publishes unique breast cancer book

The handbook on breast cancer is designed to help increase awareness among physicians, especially those in primary care, that communication with patients is key.

Information, and sometimes a lot of it, is the essence of good diagnosis and treatment. But communications, the routing of information, is often where good intentions disintegrate. Sometimes it's the physician-to-patient link. Other times, it's the physician-to-physician link. It can also be the physician-to-patient link.

In the fall of 1998, the OSMA Educational Services Department began the Breast Cancer Educational Project, part three of the five-part Women's Health Initiative series, with the purpose of disseminating useful information on communication and risk management techniques, referral management, treatment options, mammography quality and screening guidelines and more.

Nine physicians comprise the advisory workgroup which is chaired by Jay Williamson, MD, Rootstown, who is a family physician and also a member of the Focused Task Force on Education. The members represent all areas of clinical experts involved in breast cancer management—primary care, radiology, surgery, and oncology. One member is also an attorney, and one is a breast cancer survivor. Because of their interest and expertise in the area of breast cancer management, the advisory workgroup members volunteered to write the handbook. (For a complete list of the workgroup see related story.)

"With only one face-to-face meeting, several phone conferences, and good cooperation among the members,



the group developed learning objectives and topic areas for the handbook," says Dr. Williamson. "Our goal is to serve the patient's interests, to emphasize screening, and to enhance appropriate referrals and the communication involved." Janet Shaw, director of Educational Services, one of four OSMA staff members working on the project, said the cooperation among the advisory members is outstanding. "They have been so cooperative and responsive to deadlines and other workgroup commitments. Their participation has been truly amazing, and we couldn't ask for a better group of physicians to work with."

Among the topics to be included in the handbook are:

- breast evaluation;
- mammography standards;
- treatment overview;
- communications; and
- risk management and prevention.

Dr. Williamson says there will also be a resource section that will include materials from the American Cancer Society, Internet sources, general references, and checklists and other patient education items.

The OSMA will distribute the handbook, free of charge, to all members who are primary care physicians or ob-

stetricians-gynecologists. OSMA members in other specialties may request a copy at no charge. Nonmember physicians in Ohio may also request copies, but will be charged a nominal fee. —
Yvonne Burry

Take Action

Distribution of the Breast Cancer Educational Project publication will take place by the end of the year. For further information on the Breast Cancer Educational Project or the Women's Health Initiative, contact the OSMA Educational Services Department at (800) 766-6762, or e-mail: education@osma.org

The handbook's authors

The following members comprise the Breast Cancer Advisory Workgroup, and are writing the handbook that will be part three of the OSMA Women's Health Initiative Project.

Jay C. Williamson, MD, chair,
Advisory Committee
Rootstown

Louis B. Brockmeier, MD
Cincinnati

W. David Dawdy, MD, chair,
Focused Task Force on Education
Westerville

Richard B. Reiling, MD, Kettering

Clara S. Ross, MD, JD, Mason

Michael J. Seider, MD, Akron

Carol Sholtis, MD, Gallipolis

Patricia A. Stafford, MD, Dublin

Michael Star, MD, Toledo

OSMA seminars

Practice management

Cash flow management/debt collection

These half-day courses will present the proper handling of patient payments and collections. Led by a representative of I.C. System, the OSMA's endorsed vendor for cash flow management and bad debt collection.

Wednesday, Nov. 3, 1-4 p.m., Academy of Medicine of Cincinnati

Thursday, Nov. 4, 9 a.m.-noon, Montgomery County Medical Society
For more information, or to register, contact Doug Evans, OSMA Membership Services, (800) 766-6762, Ext. 6774, or you can register online by going to the Educational Services section of the OSMA Web site www.osma.org.

Workers' compensation safety/claims management

Learn how to decrease risk in your practice and how to submit claims

properly in these half-day programs. There will be an opportunity for personal consultation as well on specific issues. Presented by Gates McDonald, OSMA's workers' compensation group rating program's third-party administrator.
Monday, Nov. 8, 8:30 a.m.-noon, Wyndham Hotel, Dublin
Tuesday, Nov. 9, 8:30 a.m.-noon, Holiday Inn, Sharonville
Friday, Nov. 12, 8:30 a.m.-noon, Holiday Inn, Strongsville
For more information, or to register, call Candy Parkison, Gates McDonald, (800) 336-4733.

Managing in a small practice

For solo practitioners and members of small (three or fewer) group practices, this full-day workshop will help you organize your day and find ways to make your practice more profitable.
Tuesday, Nov. 9, Kings Island Resort

continued on page 11

OSMA seminars

continued from page 10

and Conference Center, Cincinnati

Wednesday, Nov. 10, OSMA

Headquarters, Columbus

Thursday, Nov. 11, Radisson Hotel,
Toledo

Friday, Nov. 12, Sheraton Suites,
Cuyahoga Falls

For more information, or to register,
contact Amy Johnston, OSMA De-
partment of Meeting Management,
(800) 766-6762, Ext. 6726, or you can
register online by going to the Educa-
tional Services section of the OSMA
Web site www.osma.org

Educational

Overview of current practice trends
for resident physicians

In cooperation with the Medical Society
of Greater Akron, the OSMA will host
an educational program for resident
physicians that will present an overview
of current practice trends, OSMA legis-
lative activities, sessions on managed
care, contracts for employed physicians,
and the basics of starting a practice. The
program has the support of the depart-
ments of graduate medical education of
Summa Health Systems and the Akron
General Hospital.

Saturday, Nov. 6, Sheraton Hotel,
Cuyahoga Falls

For more information or to register,
call Shar Wackman, OSMA Depart-
ment of Membership Services, (800)
766-6762, Ext. 6773.

Mahoning offers heart seminar

The Mahoning County Medical Soci-
ety and the Northeast Ohio Univer-
sities College of Medicine are co-sponsoring
a seminar, "Cardiovascular Disease
Risk Management in the New Mil-
lennium," to be held Thursday, Nov. 18 at the
Holiday Inn in Boardman.

MCMS President Thomas N. Detesco,
MD, will open the half-day conference,
followed by Michael E. Melvor, MD, who
will address the subject of cardiovascular
risk management. In addition, F. Wilford
Gemino, MD, will present "New and
Emerging Risk Factors in the Preven-
tion of Coronary Artery Disease."

Also, AMA President-Elect Randolph
D. Smoak, Jr., MD, will speak on "New
Issues for the New Millennium."

For additional information about the
seminar, contact Eleanor Pershing, MCMS
executive director, (330) 758-1624.

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President's Perspectives

Vote and vote often

By the time you read this, you will have already visited the polls and voted. At least I hope you voted. I know there are no high-stake races this year...no make-or-break issues that sway you to one candidate or another, unless it's at the local level. But it's important that you vote and that you become comfortable with the practice of voting, because medicine needs your voice, and that will be especially true next year.



Dr. Ullok

In this issue, you will find a story about the 2000 elections. I encourage you to read it so that you can better understand the stakes involved for our profession and our patients. Most of the focus, of course, will be on the presidential race. That will be an important one, as will be the races for our Congressional representatives. Now, more than ever, we need a strong voice in Washington. Congress tackles a number of health-care issues each year, so physician input into legislative decision-makers is vital. Who do you want deciding on such issues as patients' rights, HMO liability, managed-care reform and the privacy of medical records? It's important that you study the candidates, then go to the polls to put the people best qualified to make these decisions in place to do so.

The same is true at the state level. Health-care topics may not dominate state politics, but they do play a very sizable role. Each year, the OSMA follows, and even helps craft, dozens of health-care bills which progress through the Statehouse. Our legislative staff works closely with state representatives and senators to ensure that medicine's voice is heard on numerous

continued on page 13

Stop school violence

The Alliance will address stopping violence in our schools at our Fall Focus '99. Fall Focus is a leadership program for our membership.

The violence in Littleton, Colorado has brought school violence to the attention of the entire nation. Recent data from the Youth Risk Behavior Survey indicates that violent behavior among U.S. adolescents had been declining, although the most recently available data from this biennial survey are from 1997. Yet gun-carrying to school is still common, multiple homicides on high school campuses seem to be increasing in frequency, and David Satcher, MD, U.S. Surgeon General, laments that 13 young people are killed from acts of violence every day in the United States.

The facts are difficult to reconcile, but more important than the issue of whether adolescents are more or less violent than they were a few years ago is the question of *what to do about it*.

We need to be concerned about really young children bullying, hitting and calling each other names in schoolyards and in the classroom. We want to set patterns of behavior early so that when they get older, we have hopefully solved at least some of the problems

before they happen.

Long-term risks exist, not only for the victims, but also for the bullies. Statistics show that one in four children who bully will have a criminal record before the age of 30.

Therefore, to start addressing this issue of school violence, OSMA Alliance is bringing SuEllen Fried to speak to our Fall Focus. Fried is a nationally known author and child advocate. Her book *Bullies and Victims: Helping Your Child Through The Schoolyard Battlefield* tackles this problem head on. We are very fortunate to have this expert come to Columbus to address this ever-growing problem of peer abuse and violence in our schools. Fried will explain how her Bullies and Victims program works and how that program can be implemented in counties around our state. Our Alliance is very excited to bring this new program to Ohio and hope it will be the beginning of a new statewide program to stop violence in our schools. — Jan Kirlin, OSMA-A President



Jan Kirlin

FAMILY PRACTICE

OHIO — Wilson Memorial Hospital (WMH) has an excellent opportunity for a Board Eligible Family Practitioner. WMH is a highly respected, not for profit, 112-bed facility located in Sidney. The physician will spend 95% of his time on patient care. Call coverage arrangements provide the physician with quality personal time. Guaranteed base salary of approximately \$130,000 to \$150,000 dependent upon qualifications with production based incentives and an excellent benefit package including medical, dental, life, long term disability, pension, vacation and sick leave. No J 1 opportunities available.

ORTHOPAEDIC SURGEON

OHIO — An excellent opportunity exists with a single specialty group of two physicians that includes a call coverage arrangement with four other orthopaedic surgeons. This growing practice has an excellent referral source from Wilson Memorial Hospital, a not for profit, 112-bed community hospital located in Sidney. Guaranteed base salary of approximately \$150,000 to \$200,000 dependent upon qualifications with production based incentives. No J 1 opportunities available.

Please reply to: Baumann & Associates, 2265 Roswell Rd., Suite 100, Marietta, GA 30062; Tel: 770-509-2237; Fax: 770-509-2238; E-mail: jbaumassoc@aol.com

President's Perspectives

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health-care bills, it would enhance our voice if we could deliver our message to legislators who welcome us, who want to hear what medicine has to say, and who even invite us to address these important issues.

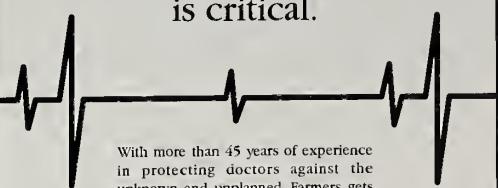
And I think I need only point to the recent Supreme Court decision overturning Ohio's tort-reform law to convince you how vital the Supreme Court races will be for medicine in the year 2000.

The bottom line is medicine needs your voice at the polls — no matter what race is at stake. If you're not sure which candidates would work well with organized medicine, I invite you

to call the OSMA a little closer to the 2000 elections. Our OMPAC office will be happy to make recommendations for those important races...both at the state and federal levels. (And now might be a good time to mention that one way to ensure the right candidate wins the right seat is to donate to our Ohio Medical Political Action Committee. OMPAC contributions help the races of candidates who have proven their ability to listen when medicine speaks.)

So vote and vote often. It's your privilege and duty as a citizen. And as a physician, it's a voice for both our profession and for our patients. ■

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Highlights of AMA's autumn activities

By Herman L. Abramowitz

Fall has been a busy season for the AMA, and this month, of course, we begin to gear up for the Interim meeting which will take place in December in San Diego.

I'll present here a few highlights of recent AMA activities which I think you'll find interesting.

AMA moves forward on bargaining unit... The AMA has taken its first steps forward in creating a national negotiating organization for employed physicians and eligible resident physicians. Until federal antitrust laws are repealed, only physicians who are employed by hospitals or other entities may engage in collective bargaining. The name chosen for the independent organization (it will operate separately



Herman L.
Abramowitz, MD

from the AMA and its Board of Trustees) is "Physicians for Responsible Negotiations." Its acronym, "PRN" is a nice play on the prescriptive language we use for "as needed." The board named five members to serve on PRN's governing body. These initial five will interview and select the remainder of the PRN governing board. Another four to seven members are expected to be chosen. Ohio is privileged to have the participant of OSMA member Andrew Thomas, MD, Columbus, as one of the initial five PRN governing board members. Andy has served as resident representative on the AMA Board of Trustees, and now represents the resident section on the OSMA Council. Other members include: Susan Hershberg Adelman, MD, a pediatric surgeon from Southfield, Michigan; John C. Nelson, MD, an obstetrician and gynecologist from Salt Lake City, Utah; Ross Rubin, an attorney and vice president for legislative affairs of the AMA; and Todd Vande Hey, vice president, private sector advocacy,

AMA. The AMA board also recommended a constitution under which PRN will be governed. The preamble of that constitution states, in part, that PRN will "advocate on behalf of our members, with the employers and others, as the law allows, to create and maintain a health-care system that guarantees all our members a working atmosphere where they can devote the time and attention their patients need."

Work continues on patients' rights, privacy bills... The AMA is closely monitoring two federal bills – a patients' rights bill and a medical records confidentiality bill. The AMA-supported patients' rights bill, now passed in the U.S. House, would allow patients to sue their employer-sponsored health plans for adverse outcomes related to medical decisions they make. Currently, employer-sponsored (or ERISA) plans are protected from the possibility of such suits. The AMA is lobbying for repeal of ERISA provisions, and has endorsed the bill

that provides the strongest right-to-sue language (for more about the federal patient rights bill, see story on page 3). The latter bill, on privacy, is prompted by a requirement of the Health Insurance Portability and Accountability Act that requires regulations on the confidentiality of electrically transferred medical information. The bill includes civil and criminal penalties for privacy violations, but a sticking point in discussions is whether or not individuals should have the right to sue if their privacy is breached. No matter which way Congress votes on this measure, the AMA advocates for stronger confidentiality laws at the state level, since states can pass laws that meet their specific needs and deal with future issues that a federal bill doesn't address.

Finally, I'll add that the AMA has taken on a public health campaign to reduce binge drinking on college campuses. The \$10 million program is

continued on page 16

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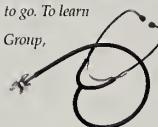
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Practice Tips

Should you earn an MBA?

The bottom line in a managed-care marketplace is learning to understand the rules of corporate decision-making. You must understand business and the business community if you seek to influence it.

The recent emergence of health maintenance organizations and managed care has made one thing perfectly clear. Physicians must have firsthand knowledge of business and leadership skills, and not simply defer management decisions or rely on a negotiator or consultant at the bargaining table.

Working smarter

"Physicians are very knowledgeable in disease management, new medications and updated technologies," says Kathleen Alter, MD, Fairfield. "But now, a huge part of the day is spent managing the logistics of daily practice. And with managed-care organizations tightening the belt, we have to work smarter." She adds, "As physicians, we need to know how our businesses work, we need to improve the quality of patient care and we must get more bang for the buck." Dr. Alter, herself a recent recipient of an executive management certificate for physicians at Johns Hopkins University, is a vocal advocate for physicians acquiring higher level business training.

"We're faced with becoming team players in the life of a health-care organization," says W. David Dawdy, MD, of Columbus. "Team play—the new role for physicians—is different than being the captain of the ship—the traditional role—in decision-making. We need to understand that the rules of corporate decision-making are different than those for clinical diagnosis and treatment. As we run our own small businesses trying to compete in today's market, we need business and management skills we were never taught," he says. Dr. Dawdy is chair of the OSMA

Focused Task Force on Education, and plays a similar role at Children's Hospital where he leads a group that decides what sort of business education is needed for the professional staff. He says that organized medicine must understand the business community if it seeks to influence it.

Courses abound

In the past decade, the opportunities for advanced business education for physicians have grown from next to nothing to nearly three dozen MBA programs nationally—directed specifically at physicians. In addition, even greater numbers of executive management programs—courses that yield certificates and/or CME credit hours but not full MBAs—have materialized. Some are very similar to the MBA courses offered in business schools, but abbreviated. Others give a broad brush stroke of business education, whetting the participants' ability to at least walk the walk and talk the talk in medical business negotiations. Another group of courses zeroes in on a limited number of very specific skills related to medical practice, such as managed care, human resource management, finance, accounting, and so on.

Among this new breed of business courses for physicians are innovative programs that capitalize on the severe time limitations already challenging most physicians. There are evening courses once a week; teleconference courses; online live and interactive sessions; readings plus online chat rooms; short on-site, intense lecture marathons—very creative uses of time. But these are all designed for physicians already in practice.

Learn as you train

The other approach is to provide much more business education for physicians in training—either while in medical school, during fellowship training or the very early years of practice.

Are you interested in an MBA?

There are a variety of physician business management programs out there, whether you're going for a full MBA or something more simple.

The OSMA Educational Services Department is interested in learning about your interest in this type of programming. Later this year, a survey will be sent to OSMA members, selected at random, to determine whether or not there is member interest in business management courses. If enough members indicate interest, the department will pursue opportunities that may lead to program offerings in this area.

If you do not receive a survey, but would like to comment on this issue, please contact Educational Services at (800) 766-6762, or e-mail: education@osma.org. The department wants to provide members with programs that are appropriate and useful, so your input is invited. ■

AMA Report

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supported by a grant from the Robert Wood Johnson Foundation, and has received already a great deal of media attention. For more information about the program, visit the AMA's Web site, www.ama-assn.org.

I'm always happy to hear from you with regard to any comments or concerns about the AMA that you may have. ■

Herman I. Abramowitz, MD
is a member of the AMA Board of Trustees, and a Past President of the OSMA.

OSMA GROUP PRACTICE DIRECTORY

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Next month, Part II will look at some specific programs being offered in Ohio and elsewhere.

Update

Prompt-pay survey will provide needed data

Before the OSMA can go to the Ohio Department of Insurance, or even legislators with complaints about slow reimbursements to physicians, hard-core data is needed.

Many physicians have complained to the OSMA that health maintenance organizations (HMOs) are tardy in meeting their 24-day, state-mandated repayment deadlines. But without hard data, it's difficult to understand the extent of the problem and how to solve it. That's why, over the summer and into the fall, OSMA has been conducting a survey.

"We originally planned to run a retrospective survey in the spring," says Todd Baker, OSMA director of Medical Economics and Advocacy. "We wanted to do a three-to-six-month look-back, and ask physicians to tell us about their claims experience – for example, how many claims were processed? how many were paid? when were they paid? But one thing we found immediately was that some physicians have office systems that

have trouble going back and tracking claims," says Baker. For that reason, the tracking strategy was amended to capture all claims during one week of practice – at the end of July. The physicians' offices then tracked those claims over a period of time into the future. Only private claims were targeted for this survey – Medicare, Medicaid and Workers' Compensation claims were excluded. The survey did not include referrals or prior authorization claims. "That's because we're trying to center on how long it takes to get a *clean claim paid*," he explained.

Good representation

"We solicited about 70 practices, by geography and by specialty," Baker says. "Among the two dozen practices that agreed to participate, there are approximately 200 physicians. They are from all over the state, in such cross specialties as family practice, oncology, pediatrics and surgery, and in practices ranging from solo to groups of 15 physicians."

OSMA asked the participating practices to break down the claims by payer, whether the claim was filed

electronically or on paper, and the magnitude of the claim – less than or more than \$100. After that, it was a tracking exercise. "The state law says the claim must be paid in 24 days, but most vendors ask for payment in 30 days, so that's considered reasonable in most business billing procedures," says Baker. "Typically, in a lot of HMO contracts we review, they build in a clause for payment in 45 days or less. Sixty days thus becomes the outer boundary of what we usually see in the length of time a practice has to wait for payment." When all the data are submitted, a well-documented view of claim payment experiences will be available.

The data being collected by survey participants will be broken down into several categories: Paid, Denied, Partially Paid, No Response and Other. "We will not include appealed claims in this study because it adds another layer of consideration and would cause us to extend the survey to at least six months," says Baker. The appeals process is an aspect of payment that OSMA might investigate in the future, says Baker, but not necessary via a survey.

Two key factors

Referring to the current survey, Baker says, "Two critical factors that interest us are situations where there is no response, and finding how quickly clean claims are paid."

When all data are collected, the OSMA expects to have a data set that includes several thousand claims and their accompanying payment situations. With the results, "We plan to use our findings as a central focus to work with the Ohio Department of Insurance to craft legislation...based on experience in the marketplace," says Baker. "Originally we floated legislation because the OSMA was concerned and wanted to speed up the payment process. But when the companies (HMOs) said,

'Prove to us that this is a problem,' we could only show it anecdotally. Now we will have a way to identify the problem and provide ways best suited to solve it," Baker adds.

Survey results were expected by mid-October. Watch future issues of *Ohio Medicine* for additional stories on this subject, including survey results. – Yvonne H. Bury

Group practice exchange

Falling reimbursements provoked Mayfield-Anthem split

Mayfield Clinic seeks to sort out the problem of lower and lower reimbursements from at least one insurer.

After Mayfield Clinic pulled out of the Anthem Blue Cross & Blue Shield network earlier this year, they heard nothing but favorable comments, says Michael Gilligan, Mayfield's president and CEO. Mayfield dropped Anthem, the area's most prominent health insurer, following a dispute over reimbursements. The split became effective Sept. 1.

In a nutshell, we were seeking an increase and they were anticipating a continuing decrease, Gilligan says. "We felt that we had provided substantial reductions in reimbursement

over the last several years – 50% to 60% – and that we didn't see any end in sight. The MCOs were gaining increased revenue from premium increases, but none of that was translating to provider reimbursements."

Mayfield, Cincinnati's largest neurosurgery practice, is a teaching arm of the University of Cincinnati. The 12-physician group takes patients regardless of their ability to pay and provides subspecialty services unavailable elsewhere within a 100-mile radius. "We can't continue the mission of this organization if we continue to take decreases year in and year out" from managed-care organizations, Gilligan says.

Recruitment problem

Despite its national ranking, the group is having difficulty attracting new talent. Neurosurgeons have cited the level of reimbursement as one reason for not settling in Cincinnati, Gilligan says, and physicians from both Mayfield and the community at large have left for areas with more favorable contracts. "The strength of the business community here over the last seven to 10 years has forced reimbursement lower," Gilligan says. "They have managed to corral employees into aggressive managed-care organizations and then have been forced with those managed-care organizations to be aggressive on reducing costs. That has come principally by reducing prices of

providers."

Physicians frustrated by their inability to negotiate with insurance companies are looking for nontraditional remedies, Gilligan says. Seeing the leverage hospitals gain by consolidating into large groups, some want to unionize. Others, like the Mayfield group, are dropping out of particular managed-care plans. "We happen to be a large group and have some leverage because of that," Gilligan says.

Unusual concession

Some of the group's patients have expressed their uneasiness about the controversy, Gilligan says. But Mayfield is so specialized, its action

Mayfield-Anthem split

Continued from page 17

is unlikely to affect the general population; a patient who needs the services of a neurosurgeon will probably rely on the recommendation of a primary care physician. To give the provider community as much notice as possible, Mayfield agreed to accept Anthem's lowered reimbursement for any patient who contacted the group for an appointment before Sept. 1, regardless of the date for which the appointment was scheduled. "That's a little bit on the unusual side," Gilligan says, "but we didn't want to put the referring physician in the situation of not having enough time to consider what alternatives he or she might have with regard to referring patients."

Most Anthem patients can still use Mayfield's services on an out-of-network basis, Gilligan says. And the

neurosurgeon's fee is a relatively minor part of the equation, he says. "The real expense is in the hospital and ancillary services, and those would be paid at the full rate by Anthem."

It's too early to tell what impact Mayfield's action will have on the group's waiting room. "If we find our patient numbers decreasing to the point that we're sitting around making paper airplanes, we'll probably go back to Anthem and say, maybe we ought to go ahead and take your patients just so our offices aren't empty," Gilligan says. "Or they might find that they are unable to get their patients seen in a timely fashion by neurosurgeons, so they might come to us. Or we might both decide that we can live without each other, and that's the way it will be."

No acrimony

Whether or not the current rift affects patient numbers, Gilligan hopes to re-establish a relationship with Anthem at some point. "Anthem is a quality company," he says. "The people are good people – I've dealt with them for years. I don't think there's any acrimony in this. It's a business decision, and hopefully we'll get together in the future.

"I don't think it's good for the community," he adds, "that doctors and insurance companies aren't working together for the betterment of patient care. I think it would be better for everybody if we would find a way to do it, but the mentality of the marketplace at the moment prevents that from happening." — *Jan Leibovitz Alroy*

Take Action

Group Practice Exchange is a new column for *Ohio Medicine*. In it you will find practice tips and ideas used by group practices that may transfer well to other group practices. If your group is involved in an activity or practice that might interest or benefit other groups in Ohio, please contact the editor of *Ohio Medicine* with your idea, for possible inclusion in this column. Karen Edwards, (800) 766-6762, Ext. 6752; fax: (614) 527-6763; e-mail: ohiomd@osmo.org.



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Your Practice Guide

Finding good employees is hard work

In today's tight labor market, the flexibility and even the recognition you offer employees may be more valuable than pay.

For the past two years, Ohio's unemployment rate has averaged below 4.3% – in March, even falling as low as 3.9%, according to figures from the Bureau of Labor Statistics. In an economy this strong, good help is hard to find.

"The words 'work' and 'ethic' don't go together anymore," says Karin E. Deffier, CPC, president of Med-Ex Services, a Cleveland-based medical employment service. "People say they want to work, but they never show up. It's really hard to find good people that have work ethics that will go to a job, stay at a job, do what they're told, do it well. It's a tough time."

That holds true not only for clerical staff but for office managers and nurses, too, Deffier says. "People expect a lot more," she says. "People out of some of the medical assisting programs come in here with no experience demanding top dollar. It doesn't happen. You have to put your time in and get the experience under your belt."

On the other hand, Deffier says,

many physicians balk at providing office workers the kind of salary and benefits packages that will entice them to stay. "The old saying, 'You get what you pay for – that's true,' she says. "If you want a good employee, you have to pay a decent salary. Paying somebody \$6 an hour, there's not a lot of incentive. People will go somewhere else for 25 cents."

To attract and keep employees, Sheila Malin, CEO of Medical Placements in Columbus, suggests that physicians:

- Offer more flexibility in workforce planning and scheduling.
- Offer more flexible job options. "Industry seems to be a little bit more progressive, in that they're implementing job sharing, flextime, or telecommuting," Malin says, "where medical offices are not quite there yet."
- Seek a diversified workforce. In addition to placing want ads and calling staffing services, consider such non-traditional means as contacting church groups, Malin says. "There's a lot of people out there who are not working due to the lack of day care availability or job-sharing availability. They may want to work part of the year, and then they head south for vacation or retirement part of the year. Or they have

children and they want to work around their children's school schedule." It may be worth it to train them well and work around their needs.

• Pay a living wage with good benefits. "A lot of doctors aren't giving any benefits," Deffier says, "not even health benefits – and this is what they do! They offer no health insurance or, if they do, it's only partially paid. No disability. No pension or 401K." As an employer herself, she knows how hard it is to find affordable benefits for a small company, Deffier says, but she also considers the employee's point of view: "If you've got a receptionist that's making \$7 to \$8 an hour, she can't afford to have \$100 to \$200 taken out of her pay. People will come in and say, 'Why would I want to work for you as a practice when I can go to the hospital, and look at all these free benefits and look how much money they're paying me.' You just can't compete. I don't think you're even going to be able to

compete at that level, but you have to come at least halfway. Not everybody wants to work at a big, huge hospital and be a number."

• Treat employees as you want to be treated. That's one of the most important items on her list, Malin says. Employees want more than a paycheck, Deffier agrees. They want to be recognized. They want to hear a morning "Hello" from their employers. Physicians, she says, "need to be in tune with their staff, maybe have more staff meetings and listen to their staff."

Spending money upfront on employees can mean savings later on, Deffier says. "If you paid somebody an extra 50 cents or a dollar an hour, you would get more out of that person. Paying somebody another dollar an hour could save you in the long run because you don't have the constant turnover." — Jan Leibovitz Alloy

Brush up on diabetes mellitus

Ohio Medicine is making available to readers a series of bi-monthly articles about Diabetes Mellitus. The information is prepared by the Ohio Diabetes Task Force and the Ohio Community Diabetes Control Program. The purpose of the series is to direct your attention to issues that physicians face in caring for patients with diabetes mellitus, including:

- Making the diagnosis of diabetes mellitus;
- Documenting the care of the patient with diabetes mellitus;
- Constraints and problems in caring for persons with diabetes mellitus;

- Syndrome X: What's important about it;
- LATA: What is it? A new way to look at an old problem;
- Diabetes mellitus in the first year of the 21st Century.

Since November is National Diabetes Month, *Ohio Medicine* offers the first article in the series, "Making the diagnosis of diabetes mellitus and deciding when to treat it," in its November issue. To order a copy, contact the *Ohio Medicine* reader response line, (800) 766-6762, Ext. 6580, and ask for Item #27-99. ■

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Your Practice Guide

Third-party update...

Business/office managers

United Healthcare

Internal review policy
explained...United Healthcare's internal review policy for commercial members says that only members can appeal a claim that has been determined to be the member's responsibility. *Contracted physicians and other network providers may not appeal a claim on behalf of a commercial member.* If this member has a question about a denied claim, he or she should call the insurer's Customer Service Department. The phone number is on the back of the member's identification card. A customer service representative will try to resolve the issue. If further review is needed, the member should send a written appeal to the Customer Service Department, which must receive the request within one year of the date of service. Because of the new Patients' Rights law (House Bill 4), supported by the OSMA, members of this plan and all others will have an additional recourse if they continue to disagree with the insurer's decision — an external review by independent medical experts. At this point, physicians and other providers may seek external review on behalf of the patient if the patient has designated the physician, in writing, as his or her representative.

Coding issues

• Frenectomy is obsolete...Frenectomy

is now considered an obsolete procedure in managing lingual frenulum pathology. Frenuloplasty, CPT code 41520, is the documented procedure of choice and is covered under the member's medical certificate of coverage when supporting criteria is met. Incision of lingual frenotomy, CPT code 41010, and excision of frenum, CPT code 41115, are frenectomies and are not eligible for coverage. The system will deny claims submitted under these codes, which will delay payments. Labial frenotomy, CPT code 40806, and excision of labial or buccal, CPT code 40819, are considered dental procedures and are not eligible for coverage under the member's medical certificate of coverage. Claims submitted under these codes will trigger denials, slowing payment.

Dermatosis code correction...

Diagnosis code 690 is reimbursable for dermatosis. The code is incorrectly listed as being reimbursable for dermatitis on page 11-21 of the United Healthcare of Ohio administrative manual.

• Urine albumin added to in-office lab listing...Urine albumin, CPT-4 code 82044 has been added to the in-office lab listing effective July 1. The test will be limited to patients with established diagnosis of diabetes (ICD-9 codes 250.00 to 250.03) and diabetes as a complication to pregnancy (ICD-9 codes 648.80 to 648.84).

• Pulse oximetry is not billed separately...Effective Oct. 1, United Healthcare will reimburse pulse

oximetry, CPT-4 codes 94760, 94761 and 94762 as a bundled service. Under CPT terminology, this service is considered technical and doesn't warrant a separate professional charge.

Aetna

Program to help reduce disability costs...Aetna has introduced "HealthWorks," a new program designed to cut disability costs by identifying workers at risk and shortening the time that disabled workers spend off the job. The program will be offered nationwide next year, and uses an "early warning system" to monitor for health threats. If a health threat is uncovered, then case managers, including disability-trained nurses and rehabilitation specialists, are sent to work with an employee's doctor to ease the patient's transition back to work. Nurses will help teach the worker how to manage his or her disability at home, and will collaborate with doctors and employers on a schedule for rehabilitation and a return to work.

Humana

Auditing policy rescinded...Effective October, Humana, Inc. has ceased auditing all physician claims for high-intensity services. At the suggestion of the Texas Medical Association and the OSMA, Humana will now only review those claims that consistently fall outside of the normal range of other physicians in the same specialty.

Ohio Medicine

A Publication of the Ohio State Medical Association

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Ohio Medicine (ISSN 0892-2545/USPS 405-200) is published monthly for \$40 a year by the Ohio State Medical Association, 3401 Mill Run Drive, Hilliard, Ohio 43026. Periodicals postage paid at Hilliard, Ohio, and at additional mailing offices. POSTMASTER: Please send address changes to **Ohio Medicine**, 3401 Mill Run Drive, Hilliard, Ohio 43026.

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Asthma inhaler law: Permission slips available

As of Nov. 2, children may carry and use asthma inhalers at school if they have permission. The Ohio Association of School Nurses has permission forms available for this purpose.

Ohio schoolchildren may now carry asthma inhalers and self-medicate, thanks to a new, OSMA-supported law that becomes ef-

fective Nov. 2. Physicians and parents must sign permission forms that allow the child to carry and use the inhaler at school.

The Ohio Association of School Nurses (OASN) has prepared a template for the required permission form. It includes the minimum information required by the law, including name and dose of the medication contained in the inhaler, dates the medication is to begin

and end, emergency phone numbers, side effects, and written instruction that outlines procedures school personnel should follow if the medication doesn't provide the expected relief.

Copies of the permission form must be provided to the principal, and the school nurse if one is assigned to the child's building.

The OASN has agreed to make their template available to OSMA

members who may have patients that fall under the law. To order a copy of the form, see "Take Action" below. ■

Take Action

To order a copy of the asthma inhaler permission form, contact the **Ohio Medicine** reader response line, (800) 766-6762, Ext. 6580, and ask for item #31-99.

Your Practice Guide

Collecting fees from divorced parents

Q • I am treating the child of divorced parents. From whom should I collect my fee?

A : That depends on who the court says is the "responsible" parent. The "responsible" parent is the one designated by the court to provide insurance or health-care coverage for the child—not necessarily the one who is providing the child's day-to-day care.

If the parent in your office is the "nonresponsible" parent, and he or she presents you with a court order that says the other parent is responsible for paying the child's health-care bills, then you may not try to collect

your payment from this nonresponsible party. In fact the nonresponsible parent is now protected by Ohio law from any such collection attempts.

However, the nonresponsible party is supposed to present you with the court order if you request it, and is obligated to provide you with "reasonable assistance and information" about the child's health-care coverage. If the nonresponsible parent fails in either regard, then the law says you may try to collect your fee from this parent as well as the "responsible" parent.

Under no circumstances, however, are you permitted to refuse to render health-care services to the child because the responsible parent fails to obtain the required coverage. ■

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Colleagues

Newsmakers

Ross C. Agnor, MD, Akron, traveled to Villahermosa, Mexico, with Operation Rainbow and performed anesthetics for more than 20 children undergoing cleft lip/cleft palate repair at the Hospital del Nino, January 1999.

Daniel Cassava, MD, Toledo, has been elected to a two-year position on the board of trustees of the Ohio Chapter of the American College of Cardiology.

Riaz Chaudhary, MD, Toledo, has been appointed to the Health Commission of Toledo.

Portrait

When Parkinson's disease ended Cincinnati orthopedic surgeon Malcolm Meyn's career, he put down the scalpel and picked up the paintbrush.

Fifteen years ago, a diagnosis of Parkinson's disease ended the orthopedic surgery career of Malcolm Meyn, MD. With his wife's encouragement, he entered law school. Upon graduating, Dr. Meyn practiced both law and medicine until a heart attack ended his law career. While he still practices medicine, Dr. Meyn is pursuing yet another challenge.

He credits his daughter Alexis for having started him painting. "She's a talented artist. She never used coloring books when she was young; she always wanted blank paper," says Dr. Meyn.

"I decided I was going to learn how to paint, so I bought some paints, a book and started on page one," Dr. Meyn says. He devotes five hours a day to his craft, painting in the morning and late in the evening. Typically, he completes two paintings per week.

John Coleman, MD, Toledo, has been named Ohio Family Physician of the Year. Dr. Coleman has been in practice for more than 40 years and is being recognized by The Ohio Academy of Family Physicians for exemplifying the highest standards of professional and community service.

Kerry Crone, MD, Cincinnati, has been appointed director of pediatric surgery at Children's Hospital Medical Center.

Margaret Dunn, MD, Dayton, has been appointed associate dean for faculty and clinical affairs at Wright State University School of Medicine. Dr. Dunn is



Margaret Dunn, MD

He never seems to be at a loss for subject matter. "Every painting I paint, I get five to six new ideas while painting," Dr. Meyn muses. His paintings range from still lifes to scenes and figures. When traveling, Dr. Meyn takes his watercolor and creates postcard size paintings.

Attending night classes at the Art Academy of Cincinnati, and the Baker-Hunt Foundation in Covington, has furthered his artistic abilities. In June, the Ran Gallery in Cincinnati exhibited Dr. Meyn's oil and watercolor paintings in conjunction with his daughter's artwork.

As Dr. Meyn continues to experiment with his own style and painting techniques, he looks to impressionist painter Cezanne, and Georges Braque, who was influential in the cubist movement. Dr. Meyn describes his first nude as a cross between cubism and abstract. In an oil painting of a backyard gazebo, he manipulates the thickness of the paint to create the appear-



ance of a rainy scene.

In addition to the Ran Gallery, the Suzanna Terrill Gallery in Cincinnati and the Row House Gallery in Milford also regularly exhibit his paintings. "I feel fortunate to be in three galleries," says Dr. Meyn. Recently, his oil painting of a stream in Montana won second prize at an annual church-sponsored art show in northern Kentucky.

With regard to Parkinson's, Dr. Meyn states simply, "I got it. I accept it and I try to deal with it." Painting has been therapeutic; it helps release stress while giving him an opportunity to work with his hands again. Dr. Meyn has suggested pursuing art as a form of stress release to others with Parkinson's disease.

Though his life has taken some unexpected turns, through his painting he has uncovered creativity that he would not have otherwise discovered. When asked what he has enjoyed most about the process of learning to paint, Dr. Meyn responds, "I like the creative aspect. I'm actually making something, producing something tangible. It's better than playing golf!" — Pamela J. Willits



Obituaries

JOHN E. ARTHUR, MD, Dublin, OH, University of Tennessee Center for Health Sciences, Memphis, TN, 1945; age 77; died Sept. 8, 1999.

FREDERICK BROCKMEIER III, MD, Cincinnati, University of Tennessee Center for Health Sciences, Memphis, TN, 1948; age 76; died Sept. 13, 1999.

GERALD G. EDISS, MD, Dayton, OH, Medical College of Virginia Commonwealth University School of Medicine, Richmond, VA, 1944; age 79; died Sept. 20, 1999.

BENJAMIN W. GILLIOTTE, MD, Westerville, OH, Baylor College of Medicine, Houston, 1950; age 79; died Sept. 1, 1999.

EDITH GITMAN, MD, Dayton, OH, Faculte de Medecine de l'Universite de Lausanne, Lausanne, Switzerland, 1936; age 86; died Sept. 27, 1999.

ELVIN C. HEDRICK, MD, Dayton, OH, Loma Linda University, School of Medicine, Loma Linda, Los Angeles, 1947; age 77; died Sept. 7, 1999.

ROBERT P. KOENIG, MD, Cincinnati, University of Cincinnati, College of Medicine, Cincinnati, 1952; age 72; died Sept. 6, 1999.

THOMAS R. LEECH, MD, Lima, OH, University of Pennsylvania, School of Medicine, Philadelphia, 1951; age 75; died Sept. 21, 1999.

FRANK F.A. RAWLING, MD, Bowling Green, OH, University of Western Ontario Faculty of Medicine, London, Ontario, 1937; age 89; died Sept. 7, 1999.

PETER TSENG, MD, Ironton, OH, College of Medicine National Taiwan University, Taipei, Formosa, 1969; age 55; Sept. 6, 1999.

ALBIN F. URANKAR, MD, Geneva, OH, Case Western Reserve University School of Medicine, Cleveland, 1943; age 82; died Sept. 18, 1999.

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Ohio Medicine

3

OSMA opposes physician profiling and makes a stand on a variety of other health-care issues, ranging from prescription services to acupuncture.

6

The Supreme Court may have the final word on the ethical dilemma: Can physicians have sex with a patient's parent or other key third party?



10

Looking for the best health-care news on the Web? OSMA staff members provide addresses for 22 don't-miss health-care sites.



15

2K is just around the corner. You don't make an effort now to test your computer systems, you may find reimbursements next year are slow to reach your practice.



17

inding MBA courses isn't difficult, and the OSMA can help. But first, we want to know what is your level of interest?



Are physicians becoming over-exposed?

New legislation would require full disclosure to the public on board actions, and malpractice suits against Ohio physicians.

Your patients may soon know more about you than you might care to reveal. If House Bill 475 passes the Ohio Legislature, profiles of all Ohio physicians, including information about malpractice judgments, board disciplinary action and revocation of hospital admitting privileges, would be readily available to the public, along with typical professional and educational information.

According to Rep. Dale Van Vygen (R-Sharonville), the bill's sponsor, the issue is accountability — and what he calls the medical profession's tendency to protect itself. He modeled his physician profiling bill after Massachusetts legislation that created the country's first physician profiles. The Massachusetts li-

censing board has published malpractice and disciplinary records of physicians for the past three years.

The OSMA Focused Task Force on State Legislation has recommended the association oppose the bill, a suggestion that's likely to be adopted next month by the OSMA Council.

"Information on medical board action is already available on the board's Web site," says Carol Mullinax, director of the Division of Public Affairs, which includes the Department of Legislation. And the malpractice information is unlikely to give a true picture of a doctor's ability,

To be revealed:

- Medical malpractice judgments and settlements.
- Disciplinary action by the medical board.
- Revocation or restriction of hospital admitting privileges.
- Felony or misdemeanor convictions, guilty, or no contest pleadings.

she adds. "With the proliferation today of malpractice lawsuits, it's often more expedient for doctors to settle than to

press forward with the case."

Expect the OSMA to monitor this bill closely as it makes its way through the Statehouse. *Ohio Medicine* will provide updates as they occur. ■

To take action

Let your state representative know about your opposition to this bill. To find your representative, contact the OSMA Department of Legislation, (800) 766-6762, Ext. 6742.

OSMA releases breast cancer handbook



Free to members...To order a copy contact the Division of Public Affairs (800) 766-6762.

Breast Cancer: Treatment, Communication and Risk Management is the latest educational handbook in the OSMA's five-part Women's Health Initiative series. The handbook focuses on the communications link between physicians and their breast cancer patients, and also includes information on risk management techniques, referral

management, treatment options, mammography quality and screening guidelines. The new handbook was released in November, free of charge, to all members who are primary care physicians or obstetrician-gynecologists. OSMA members in other specialties may request a copy at no charge. ■



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Bills, Laws & Rules

New legislative positions

OSMA opposes profiling bill

Point-of-service, pharmacists administering drugs, needle safety and, dietary supplements were among the 18 bills considered by the OSMA Focused Task Force on State Legislation.

The OSMA Focused Task Force on State Legislation met recently to consider new health-care bills introduced in the Ohio Legislature. Following is a look at the bills and how the committee voted. These recommendations must still be approved by the OSMA Council next month before they are considered official OSMA positions. If you have questions or would like more information about any of these measures or the positions recommended, contact the OSMA, (800) 766-6762, and ask for the appropriate OSMA staff member (given with each bill.)

Support

SB 126. Health plans

Requires an HMO to furnish an application to any health-care provider seeking to enter into a participation contract with the HMO. Also reduces from 120 to 90 days the period in which an HMO is to notify a provider of the status of the provider's application; requires an HMO to provide a written explanation to any provider denied a participation contract; and deems an HMO's failure to act on an application within 120 days a denial.

Sponsor: Sen. Gregory DiDonato (D-Cambridge)

OSMA position: Support

OSMA staff: Nick Lashutka, Ext. 6747

SB 173. Tuberculosis control

Concerning the prevention and control of tuberculosis.

Sponsor: Sen. Grace Drake (R-Solon)

OSMA position: Support with

technical assistance

OSMA staff: Marla Eshelman Bump, Ext. 6741



HB 307.

Prescription services

Relates to coverage for prescription drug services provided by "any willing pharmacies" under policies of sickness and accident insurers and HMOs.

Sponsor: Rep. Bryan Williams (R-Akron)

OSMA position: Support

OSMA staff: Nick Lashutka, Ext. 6747

HB 346. Tobacco enforcement

Authorizes a department of public safety enforcement agent to arrest and detain without warrant a person illegally distributing cigarettes or other tobacco products to minors.

Sponsor: Rep. Ray Miller (D-Columbus)

OSMA position: Support

OSMA staff: Marla Eshelman Bump, Ext. 6741

HB 428. Drug schedule

Classifies gamma-hydroxy-butyrate as a Schedule II controlled substance and updates the state controlled substances schedules in accordance with federal drug laws.

Sponsor: Rep. Charles Calvert (R-Medina)

OSMA position: Support

OSMA staff: Krista Bistline, Ext. 6748

HB 461. Health-care contracts

Prohibits HMOs, sickness and accident insurers and third-party administrators from using "most favored nation" clauses when contracting with providers or health-care facilities.

Sponsor: Rep. Dale Van Vyven (R-

Sharonville)

OSMA position: Support

OSMA staff: Nick Lashutka, Ext. 6747

SB 147. Diabetes insurance

Requires certain health-care policies, contracts, agreements, and plans to provide benefits for equipment, supplies, and medication for the diagnosis, treatment, and management of diabetes and for diabetes self-management education.

Sponsor: Sen. Grace Drake (R-Solon)

OSMA position: Neutral with technical assistance

OSMA staff: Nick Lashutka, Ext. 6747

Neutral

HB 455. Tobacco settlement

Establishes the Minority Health

Tobacco Settlement Fund and provides that a percentage of the funds from the tobacco settlement agreement are to be used by the Commission on Minority Health to make grants to organizations that serve the health needs of minority group members.

Sponsor: Rep. Ray Miller (D-Columbus)

OSMA position: Neutral

OSMA staff: Marla Eshelman Bump, Ext. 6741

Oppose

SB 154. Physician profiles

Requires the State Medical Board to create physician profiles and makes them available to the public. (See front-page story for additional information.)

Sponsor: Sen. Bob Hagan (D-Youngstown)

OSMA position: Active opposition

OSMA staff: Tim Maglione, Ext. 6746

HB 305. Physical therapy

Allows patients direct access to physical therapists, and makes other changes in the law governing physical therapy.

Legislative update

Supreme court rejects AG request...

The Ohio Supreme Court rejected the state request, filed by Attorney General Betty D. Montgomery, to reconsider its decision invalidating the state's tort-reform law. The vote to deny reconsideration was along the same lines as the vote in the court's original decision.

Narcolepsy patients don't need to worry...

According to Tim Benedict of the Ohio State Board of Pharmacy who testified recently on House Bill 428, if the bill passes and gamma-hydroxybutrate (GHB) is made a schedule II controlled substance, narcolepsy patients would still be able to obtain the drug for treatment. The bill has passed the House and is now in the Senate.

Mental health parity bill still in House... S.R. Thorward, MD, testified in support of House Bill 53, the mental health parity bill that prohibits discrimination in health-care policies regarding the treatment of mental illness, substance abuse or addiction. He represented both the Ohio Psychiatric Association and the OSMA.



Trauma bill amendments add protocols for children...

Legislators have amended House Bill 138, creating a statewide trauma system, to establish separate trauma protocols for children. The bill would now require hospitals to transport children with trauma injuries to hospitals that can treat them.

Bill would prohibit "most favored nation" clauses... If passed, House Bill 461 would eliminate "most favored nation" clauses, provisions which allow HMOs and other third parties to secure the lowest rate when contracting with providers or health-care facilities. Currently, Anthem Blue Cross and Blue Shield is the only Ohio insurer known to use these clauses. The legislation was prompted by the Ohio Hospital Association which sees such provisions as increasing hospitals' costs of doing business.

Continued on page 4

legislative update

Continued from page 3

Alternative medicine, acupuncture bill OK'd. House Bill 90, allowing physicians to use alternative medical treatments if the benefits outweigh the risks, has passed the House and moved to the Senate for hearings. The House also OK'd House Bill 341, which allows credentialed acupuncturists to practice in Ohio, under the supervision of a physician.

Hearing tests for newborns?... House Bill 480, introduced by Rep. Johnnie Maier, Jr. (D-Massillon), requires a hearing screening for each newborn born in a hospital.



Physical therapists must refer after fifth visit.... If House Bill 305 passes and patients gain direct access to physical therapists, new amendments call for the physical therapist to refer a patient to a physician after the fifth visit or 15 days, whichever comes first. Also substantial rather than measurable progress must be made by the patient to avoid referral.

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Sponsor: Rep. Kevin Coughlin (R-Cuyahoga Falls)
OSMA position: Opposition
OSMA staff: Marla Eshelman Bump, Ext. 6741

SB 111. Dialysis technicians
Provides for certification of dialysis technicians and approval of dialysis training program by the Board of Nursing.
Sponsor: Sen. Grace Drake (R-Solon)
OSMA position: Under advisement (Changed from a position of active opposition after the committee received additional information on the need to standardize education in this area.)
OSMA staff: Marla Eshelman Bump, Ext. 6741

SB 163. Health insurance
Requires all closed-panel plans offered by HMOs to allow enrollees to use nonparticipating providers and imposes on such enrollees a co-payment, deductible, or other out-of-pocket expense that reflects the HMO's certified actual costs.
Sponsor: Sen. Louis Blessing (R-Cincinnati)
OSMA position: Under advisement
OSMA staff: Nick Lashutka, Ext. 6747

SB 172. Pharmacists



Establishes a pharmacist-client testimonial privilege, permits a pharmacist who has completed a course in drug administration, approved by the pharmacy board, to administer drugs, and revises the law governing consult agreements between physicians and pharmacists.

Sponsor: Sen. Grace Drake (R-Solon)
OSMA position: Under advisement
OSMA staff: Marla Eshelman Bump, Ext. 6741

SB 183. Needlesafety
Requires each public employer that employs public health-care workers to develop an exposure

control plan incorporating the use of needleless systems and sharps with injury protection devices.

Sponsor: Sen. Dan Brady (D-Cleveland)
OSMA position: Under advisement
OSMA staff: Marla Eshelman Bump, Ext. 6741

HB 341. Acupuncture
Requires anyone practicing acupuncture to be designated as a current and active diplomat in

acupuncture by the national acupuncture certification commission. Also requires acupuncturists to work under the direct supervision

of a physician and to practice only upon the referral or prescription of a physician.

Sponsor: Rep. Kirk Schuring (R-Canton)
OSMA position: Under advisement
OSMA staff: Marla Eshelman Bump, Ext. 6741

HB 351. Partial birth infanticide
Creates the offense of partial birth infanticide; allows specified persons to commence a civil action for damages when a child is killed by partial birth infanticide; and repeals the prohibition against performing a dilation and extraction procedure on a pregnant woman and the related civil action.

Sponsor: Rep. Jerry Luebbers (D-Cincinnati)
OSMA position: Under advisement
OSMA staff: Marla Eshelman Bump, Ext. 6741

HB 414. Drug sales
Prohibits the selling of certain drugs in excess of the quantity and concentration or length of time of use approved by the U.S. Food and Drug Administration.

Sponsor: Rep. Jack Ford (D-Toledo)
OSMA position: Under advisement
OSMA staff: Krista Bistline, Ext. 6748

HB 458. Dietary supplements
Defines "dietary supplement," regulates the labeling and packaging of dietary supplements, requires manufacturers of dietary supplements in this state to register annually with the

Director of Agriculture, requires the director to conduct random inspections of establishments where dietary supplements are manufactured, processed, packed, or held for introduction into commerce, and makes other provisions.

Sponsor: Rep. Ray Miller (D-Columbus)
OSMA position: Under advisement
OSMA staff: Krista Bistline, Ext. 6748



The Women's Health Initiative

The OSMA's five-part series on women's health offers educational handbooks on the following subjects:

- Osteoporosis
- Domestic violence
- Breast cancer

All of the handbooks include continuing medical education credit.

Next year, the final two books in the series, including one on women's cardiac health, will be distributed. If you would like a copy of one or all of the Women's Health Initiative handbooks, contact Robin Parker:

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Patient restraints

The new one-hour rule

According to HCFA's new rules on patient restraints, you have one hour to go, see, and evaluate your patient's need for restraints.

The Health Care Financing Administration didn't wait for comments on its interim final rules on patient restraints before putting them into effect. Here are some of the comments that HCFA didn't wait to hear.

OHA: The Association for Hospitals and Health Systems

"The rule should be amended to state that a physician be called within an hour after a patient is put in restraints."

The OHA also asked HCFA to clarify terms such as "behavioral management." Hospitals question, for example, whether the standards apply if an arm restraint is used to prevent a patient from removing an IV or feeding tube.



Walter J. Wielkiewicz, MD
President-Elect, OSMA

"If I'm in my office and I have a patient who needs a restraint for their own safety, it isn't always practical to leave all of my patients in the office and get to the hospital within an hour. I really don't think it's going to improve patient care to have me or any physician have to see a patient within an hour."



Ohio Department of Mental Health

The ODMH prepared a response to HCFA that identified eight problem areas, including:

- 1.) Definition of restraint. Does it include therapeutic holding and comforting of children?
- 2.) Definition of seclusion. Does it include timeouts, open-door room restrictions and secured units?
- 3.) Use of seclusion or restraint in emergency situations. If "seclusion" is all inclusive, timeouts and open-door room restrictions can no longer be used in behavioral plans.
- 4.) PRN orders for medication for agitation appear to no longer be permitted. Now, a physician needs to be called for an order each time, delaying the administration of medication.



E. Ratcliffe Anderson, Jr., MD
Executive Vice President, CEO, AMA

"The policy puts an undue and unfair burden on all hospitals to perform a type of evaluation that is not medically or clinically necessary in all cases." — Jan Leibovitz Alroy

Take Action

For more information about the new patient restraint rules, contact the AMA (312) 464-5000, the Ohio Department of Mental Health (614) 466-2596 or the Ohio Hospital Association, (614) 221-7614.



Gladieux to appeal to Supreme Court

The medical board suspended Dr. Gladieux's license for two years for having sex with the mothers of his pediatric patients. Two courts have upheld the suspension. Now, the Supreme Court may hear the case.

Two years ago, the State Medical Board of Ohio suspended the license of pediatrician Gary Gladieux, MD, for having sex with at least seven of his patients' mothers. The Franklin County Court of Appeals upheld the suspension recently, but Dr. Gladieux, a Swanton pediatrician, now wants the Ohio Supreme Court to hear the matter. Dr. Gladieux has contended through-

out the process that there are no written rules that prohibit doctors having sex with their patients' relatives.

Physicians and ethics experts have said, however, that a doctor's relationship with key third parties, such as a parent, could affect the physician's professional objectivity. And last year, the AMA adopted a policy that says it's unethical for physicians to have sex with their patients' spouses, parents, guardians, or surrogates.

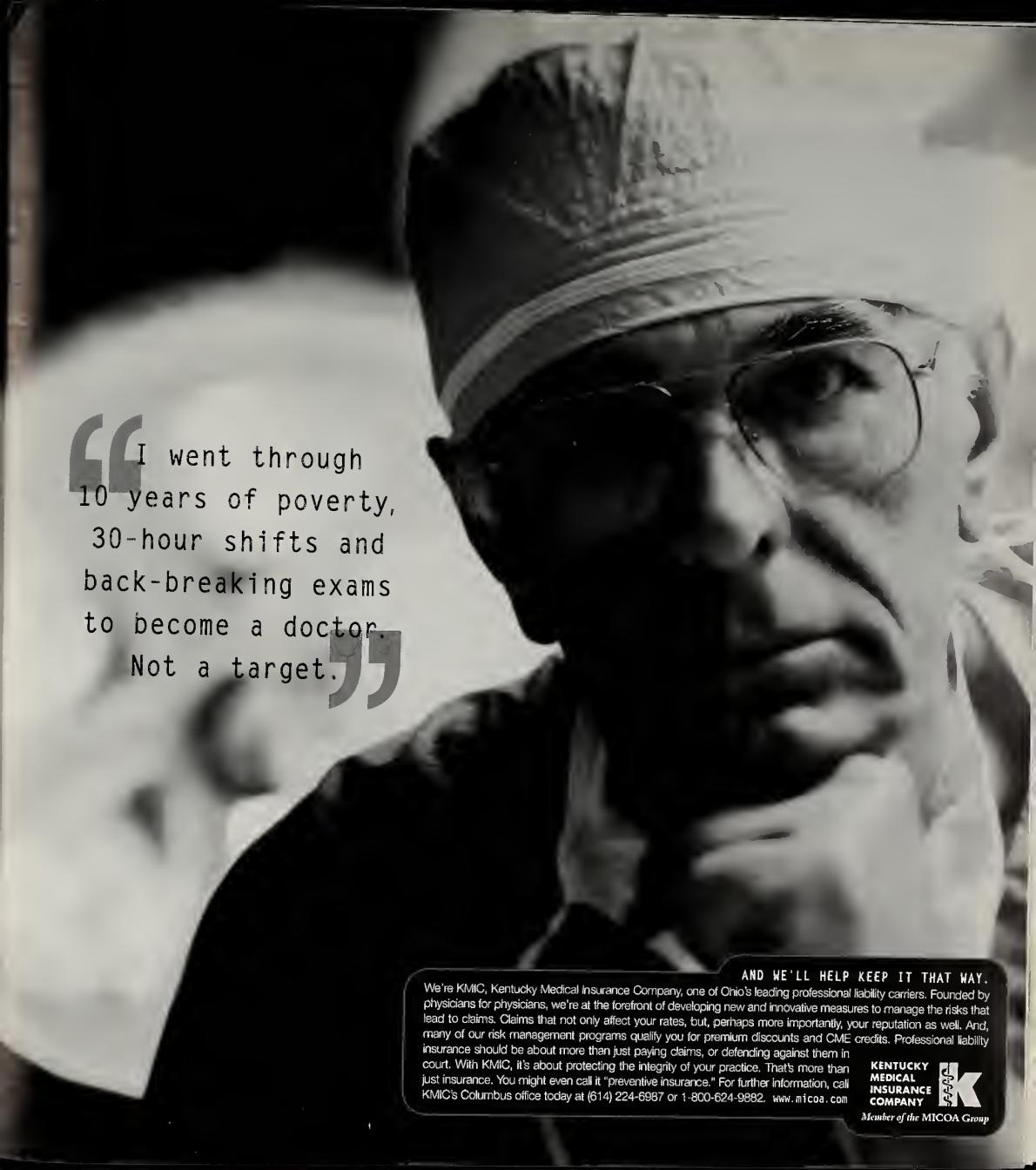
The medical board's decision to suspend Dr. Gladieux's license for two years has been upheld by the Franklin County Common Pleas Court, in addition to the court of appeals. Pending exhaustion of all appeals, Dr. Gladieux

has been allowed to continue to practice, however, he is not permitted to have unescorted contact with patients' female relatives, and he was required to write every family of current and new patients about his suspension.

In a similar case that occurred in 1990, Pablo A. Pons, MD, a Toledo obstetrician-gynecologist, had his license suspended for one year by the board when the board ruled that his affair with a patient was unethical. Dr. Pons also tried to appeal on the basis that there were no written rules against sex with patients, but the Ohio Supreme Court upheld the board's suspension of Pons' license. ■



A physician's relationship with key third parties could affect objectivity.



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OSMA's handbook, educates doctors on managing pain.

Oregon doctor disciplined for under treating pain

Ohio legislators expect this state's physicians to be more knowledgeable on treating and managing chronic pain. If you're not, the OSMA's *Pain: The Fifth Vital Sign* can help.

An Oregon pulmonary specialist is the first doctor in the country to be disciplined by a state medical board for under-treating his patients' pain. Mark Bilder, MD, was disciplined for failing to give six patients sufficient relief from pain. According to news reports, Dr. Bilder gave only Tylenol to a man dying from cancer, refused to give pain relief to a ventilator patient, and would not prescribe anything stronger than over-the-counter drugs to an 82-year-old woman suffering congestive heart failure.

Dr. Bilder was charged with "unprofessional or dishonorable conduct" and "gross negligence or repeated negligence." He agreed to enroll in a peer evaluation and education program run by the Oregon Medical Association, and complete a course on physician-patient communication.

Early this year, the OSMA launched a pain initiative, designed to educate all Ohio physicians on the treatment of chronic pain. A survey that preceded the initiative disclosed that while 60% of Ohio physicians said they prescribed pain medication "often" and an additional 23% said they do "somewhat often," only 24% described themselves as "very knowledgeable" in pain management and relevant technological improvements. An additional 66% reported they were "somewhat knowledgeable."

In January, the OSMA sent *Pain: The*

Continued on page 9

Oregon doctor

Continued from page 8

Fifth Vital Sign, educational materials approved for CME credit to all physicians licensed in Ohio. To date, about 1,400 pain self-tests have been returned to the OSMA, indicating that knowledge of pain management in Ohio's medical community continues to grow.

If you did not receive or have misplaced your copy of the OSMA's educational packet, *Pain: The Fifth Vital Sign*, see "Take Action" below. If you have not yet taken the self-test and returned it to the OSMA, you are urged to do so.

The State Medical Board of Ohio has created a pain committee to review matters related to the subject of treating and managing chronic pain, including monitoring the effects of the pain law that passed last year.

If you are uncertain about your own knowledge in the area of treating pain, don't hesitate to brush up on this subject, with help from the OSMA's pain handbook. It's a good move for medicine...and it's a good move for your patients. ■

Take Action

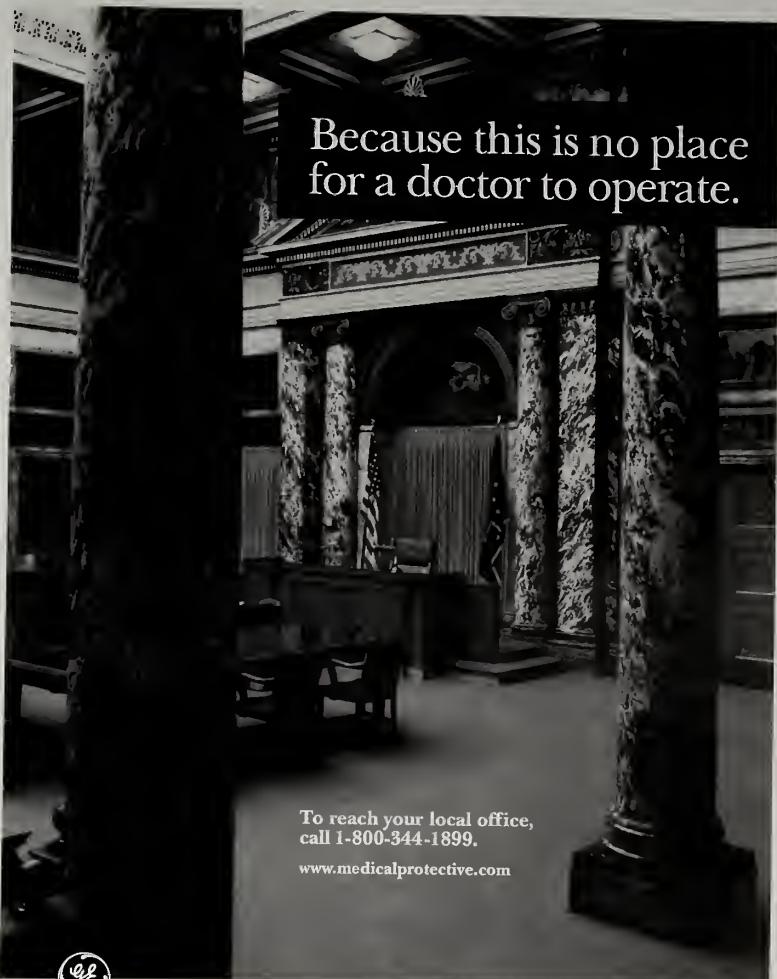
If you would like a copy of the OSMA's educational pain initiative *Pain: The Fifth Vital Sign*, contact the OSMA Department of Communications (800) 766-6762, Ext. 6744. You will be sent a copy.

Quotes



"The department does not believe that an open-heart surgery service is the only criteria that should be utilized to ensure the health and safety of patients."

—Nick Baird, MD
Director, Ohio Department of Health
(In recommending to legislators that new cardiac cath labs don't need on-site open-heart surgery backup.)



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OSMA News



The 22 best Web sites

Which Web sites are worth your while? OSMA staff members present their picks of the top health-care socioeconomic sites.

www.nationwide-medicare.com

Come here for Medicare Part B carrier information, including both the Ohio and West Virginia fee schedule, overpayment refund information and online form, and review/hearing request forms.

Suggested by: Jennifer Hyle,
Department of Ombudsman Services

www.ohanet.org/resources/newsroom

This is the place to find Ohio Hospital Association publications, where you'll find timely health-care issues and trends. Suggested by: Kent Studebaker, Division of Operations

rc.ava.com/search.htm

Need to look up a law? This site will enable you to search the Ohio Revised Code.

Suggested by: Kent Studebaker, Division of Operations

[www.ama-assn.org/ physleg/legal/legal.htm](http://www.ama-assn.org/physleg/legal/legal.htm)

For general information about legal issues affecting medical practice, you can't beat this AMA site.

Suggested by: Tim Maglione, Department of Legislation

www.legislature.state.oh.us

Come here to search for current Ohio legislation and analyses by bill number or keyword.

Suggested by: Tim Maglione, Department of Legislation

www.askmed.com

This site will provide you with background information on any physician licensed to practice in the U.S. Note: There is a fee per report. Suggested by: Almetta Cooper, Division of Legal Affairs

www.ohiobwc.com

If you're looking for Ohio Bureau of Workers' Compensation information, such as downloadable First Report of Injury (FROI) forms and employer/MCO lookup, this is the site to visit.

Suggested by: Almetta Cooper, Division of Legal Affairs

www.ahcpr.gov

Here's the place to come to access Agency for Health Care Policy and Research reports.

Suggested by: Janet Shaw, Department of Educational Services

www.mgma.org and www.anga.org

The first site presents the Medical Group Management Association; on the second site is the American Medical Group Association. Check them both out for group management news.

Suggested by: Susan Rupli, Department of Group Practice Services

managedcare.medscape.com

Come to this site for managed-care news, trends, legal matters, treatment update and conference summaries.

Suggested by: Brent Mulgrew, Executive Director

www.ahanews.com

Here's where to access the current *American Hospital News* weekly newsletter.

Suggested by: Brent Mulgrew, Executive Director

www.hcfa.gov

If you're looking for anything related to HCFA, you'll want to visit this site first.

Suggested by: Todd Baker, Medical Economics and Advocacy

www.ohio.gov/ins

Come here for Ohio Department of Insurance news releases, publications, legislation, rules, bulletins, and the list of authorized insurance companies.

Suggested by: Todd Baker, Medical Economics and Advocacy

www.webmd.com

This is a physician subscription service (the first month is free) that integrates multiple administrative, communications and research functions into a single site.

Suggested by: Ben Reynolds, Northeast Ohio Field Representative

www.state.oh.us.med

This is the Web site for the State Medical Board of Ohio. Here you'll find CME requirements and renewal facts, policies, guidelines and adopted rules.

Suggested by: Janet Shaw, Department of Educational Services

www.osma.org

Check and see what your counterparts in other states are doing. Now you can visit other state medical associations — California, Texas, Michigan — through the OSMA links page.

Suggested by: Karen Kirk, Division of Public Affairs

Reporting System.

Suggested by: Suzanne Byrd, Division of Public Affairs

www.cdc.gov

This site provides Centers for Disease Control data and statistics, traveler's health advisories, alphabetical health topics, current health news and downloadable educational resources.

Suggested by: Suzanne Byrd, Division of Public Affairs

www.congress.nw.dc.us/alsa/

Use this site to access your state legislators' profiles as well as OSMA-provided letters on current medical legislative issues you can send to your Ohio legislator online, over your own signature. Link from the OSMA site.

Suggested by: Carol Mullinax, Division of Public Affairs

www.state.oh.us/scripts/med/license/Query.htm

Come to this site to check the accuracy of your own state license profile and status. It's part of the State Medical Board of Ohio's Web site.

Suggested by: Carol Mullinax, Division of Public Affairs

www.acpe.org

This address will let you reach the Web site for the American College of Physician Executives.

Suggested by: Shar Wackman, Division of Membership Services

www.odh.state.oh.us

The Ohio Department of Health's Web site includes its warehouse of vital statistics. Look here for births and deaths, including Healthy People 2000 groupings. The site will soon add disease incidence statistics, with counts for individual communities.

Suggested by: Karen Edwards, *Ohio Medicine*
— Carol Larimer



Click! You're there!

The OSMA's Web site can link you to more than 100 popular Web sites.

In the Wizard of Oz,
Dorothy had

only to click her ruby slippers together three times and she was home. Three clicks of your mouse can transport you to equally magical places, courtesy of www.osma.org.

If you haven't visited the "links" page on the OSMA Web site lately, maybe it's time you did. The links page has been reorganized into categories which will make it easier for you to find other useful sites such as state government agencies, national government agencies, specialty societies/associations, selected media, local insurance/managed-care organizations and Ohio medical schools.

While you may have some of these sites bookmarked, isn't it easier to call up the OSMA site and have all this information at your fingertips? To reach the link you want, click through the OSMA home page through the "Entry" button (1); click on the "links" navigation button (2); and finally, click on the Web site you want to visit (3).



One of the new features of the links page is a list of other state medical associations. Now you can visit California, Texas, Michigan and other state societies through their Web sites. Check and see what your counterparts in other states are doing.

A number of Ohio county medical societies have recently designed their own Web sites, or have updated older sites. Go to the links page and look under county medical societies to get the latest information in your district.

If you know of a site that should be included on the OSMA links page contact Karen Kirk at kkirk@osma.org. ■

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Medicare is Y2K ready. Are you?

Same question, different answer

As OSMA president, one of the questions I find myself fielding from members and non-members alike is what does the OSMA do for me?



Dr. Ullok

I'm sure there isn't an OSMA president who hasn't had to step up to the plate and explain the value of organized medicine in general and the OSMA in particular. Our answers may be different, however, because the OSMA is a fluid organization, and continues to grow in both its service and mission.

May I suggest that if you find yourself questioning the benefits you receive for your dues dollars, it may be because you haven't made yourself completely familiar with all the services your association provides? I'm surprised by the number of members I talk with who are unaware that the OSMA offers a contract review service through our Division of Legal Affairs. Before you sign your next contract, take a minute to call the OSMA and ask legal services to send you the contract review for the third party you are signing with. Our review may just save you from some potentially expensive errors. And if you're already under contract with an insurer or HMO and experiencing problems of some sort, contact the OSMA Ombudsman Services Department. Ombudsman staff members will provide individual and confidential assistance in resolving your problem.

These are just two examples. There are plenty more. I've already used this space in the past to describe how our legislative efforts have secured greater access to health care and more rights for our patients. We continue to monitor bills that threaten the delivery of high-quality health care to Ohioans. In other words, your dues enable you to continue to serve as your patients' advocate, not on an individual basis but as a collective force and voice that has the ability to make legislators listen. With that voice, we have been able to secure a patients' rights bill and meaningful,

President's Perspectives

significant managed-care reform.

Don't forget that your dues have bought you a wealth of continuing educational activities. The OSMA serves as an accrediting body, enabling Ohio programs and facilities to present you with a range of educational opportunities. We also offer our own educational offerings – for example, the comprehensive handbook on managing chronic pain, distributed to all Ohio physicians this past January, and the five-part Women's Health Initiative project. By now, you should have received information about osteoporosis, domestic violence and breast cancer. Soon you'll have material that features cardiac care for women. A fifth subject is still under discussion.

Finally, the money you spend on dues brings you each month, and throughout the year all the latest news you need to know about the health-care scene in Ohio. Through *Ohio Medicine, Leadership Briefing, Medical Staff Bulletin*, and the OSMA Web site, you have access to reports from the medical board, what's happening at the Statehouse, how your professional liability company rates, and, next year, quarterly reports on the financial strength of Ohio's HMOs.

As this year draws to a close, I hope you reflect on the benefits the OSMA has brought you this year, and I hope you resolve to make yourself more familiar with your association in the future. The OSMA can serve you in many ways, but first, you need to know about the services and benefits we offer so you can put your dues to work for you.

Enjoy your holidays. ■

Toke Action

If you would like an updated copy of the OSMA's "Services and Benefits" handbook, contact Lucy Kimer, OSMA Department of Membership Services, (800) 766-6762, Ext. 6776.



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Federation of Medicine

AMA Report

Online privacy a new AMA concern

By Herman I. Abromowitz, MD

In addition to my responsibilities as a member of the AMA Board of Trustees, I also maintain an active schedule of appearances on behalf of the AMA. I have already mentioned in a previous column my testimony before the U.S. House Subcommittee on Internet drug prescribing. More recently, I met on the same subject in Chicago with the attorney general of Illinois. In September, I addressed the Congress of Delegates at the 1999 meeting of the American Academy of Family Physicians in Orlando, Florida. In early October, I was the keynote speaker for the opening session of the National Convention of the American Association of Medical Assistants, and in late October, I was in Portland, Oregon to address the subject of disease management.



Herman I.
Abromowitz, MD

ment with members of the Oregon medical insurance pool.

I want to update you, though, on some of AMA's most current and pressing activities:

• Securing online privacy

The AMA has announced that it will join with Intel Corp. to introduce new safeguards for medical confidentiality on the Internet. There is no question that the potential for the Internet to be used to obtain lab results, send prescriptions to pharmacies and receive patient files makes it important that security systems are in place so that patient privacy and confidentiality are protected. By taking such steps, we can enable a wide variety of routine medical transactions to occur online, a benefit both to us, and to our patients.

• Next step for patients' rights

The efforts of the entire federation of medicine helped mobilize grassroots action that led, eventually, to the passage

of the Norwood-Dingell patients' rights bill. This is an important victory for our patients. The AMA will now turn its attention to urging the U.S. House-Senate conference committee to adopt the Norwood-Dingell bill (HR 2723) and turn this important legislation into law.

• Antitrust update

Whether or not physicians who are not employed by medical facilities will have the right to negotiate contracts will depend, to a great extent, on the outcome of a federal bill that changes current anti-trust laws. In order for all physicians to have a greater voice in their health-care contracts, it's important that HR 1304 pass Congress. Currently there are more than 160 co-sponsors of Rep. Thomas Campbell's (R-California) bill. To see if your representatives support the "Quality Health Care Coalition Act of 1999" check the AMA Web site. You can link to it from the OSMA Web site, www.osma.org.

• PRN update

The board for the newly-formed Physicians for Responsible Negotiations (PRN) is now complete. The nine-member PRN governing body will move quickly to adopt a constitution for its independent organization and is expected to be ready to help interested, eligible physician groups by year's end. When it is up and running, PRN will serve as a negotiating unit for physicians. Andy Thomas, MD, Columbus, who serves as the resident representative on the OSMA Council, and is a former resident representative of the AMA Board of Trustees, serves as a member of the PRN's governing board.

• Coordinating performance measurement activities

The Performance Measurement Coordinating Council (PMCC) confirmed that the first area for

Continued on page 18

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Practice Tips



Tick...Tick...Tick

The millennium approaches. Is your practice ready for Y2K? Maybe...Maybe not.

Think you're ready for Y2K? You may need to think again. According to the Health-Care Financing Administration (HCFA), the majority of Ohio physicians have yet to submit a Y2K date verification test with Nationwide Medicare.

To help you determine whether or not your practice is ready for the year 2000, check out the following myths vs. realities, as prepared by HCFA. You may be in for a surprise. (And no, it's not too late to make adjustments, as long as the calendar still reads 1999.)

Myth: I'll just print paper claims if I can't generate an electronic claim.

Reality: If your system can't produce an electronic submission, it's not likely to print a paper claim either. Even if it could, HCFA's contractors simply will not be able to process paper claims on a timely basis. An influx of paper claims are likely to result in payment backlogs.

Myth: If I can't submit claims on Jan. 1, 2000, HCFA will send me an advance payment.

Reality: HCFA has clearly stated it will not be making advance payments as part of its contingency plan. Being able to submit a valid claim to HCFA is the minimal requirement health-care providers must meet to receive payment from Medicare.

Myth: If you can send a Y2K compliant claim to your contractor today, as HCFA required by April 5, 1999, your systems are millennium ready.

Reality: Unfortunately, this isn't true. All your systems that interface to produce a compliant claim and other electronic transactions must be renovated and tested.

Myth: Testing doesn't uncover any problems.

Reality: Significant problems have been found by Medicare contractors in testing with providers. That's why it's critical that providers test and test early. It allows them time to make necessary corrections in time for the millennium rollover.

Myth: I made changes and renovations to my systems, so I don't need to do any testing.

Reality: Even if you believe your billing system is compliant, you should test your entire system to make sure you can generate a future-dated claim, and then test with your contractor's front-end system.



Myth: If some other provider tests, using the same billing software I use, then I don't need to test.

Reality: Yes, you do need to test the same software because that other provider may have a different hardware system than you. Just because one provider's claims went through smoothly does not mean that you won't run into problems when you do your testing.

How to test

The following steps to test your office systems have been provided by Nationwide Medicare.

1.) Set your system date to the year 2000 or beyond while creating the Y2K test claim.

Check with your system support to ensure that the system date is shown in the creation date field on your electronic format. Keep in mind the system date must be beyond the dates used on the test claims. Also note that the system date will need to be changed back to the current date once you've created your Y2K test claims file.

2.) Y2K tests must be submitted to the current test line number at (614) 277-6106. (For modems – not a phone line)

After transmission, you must download your message file to determine if the file was successfully received by our system.

3.) Once you've received a "Test Successful" message from your message file, call the EDI technical support area, (614) 277-6100, to inform a representative that a Y2K test has been submitted.

You'll be asked for your name; PIN number; and the name, complete address and phone number of the contact person to receive the Date Verification test results.

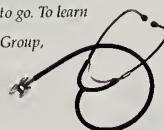
An EDI specialist will mail a copy of the test results to the contact person. Y2K test results should consist of only 15 claims, and should contain actual patient and service data using future dates. You should test all date fields you use. HCFA recommends you test all of the following dates:

- 12/31/99
- 01/01/00
- 01/03/00
- 01/04/00
- 02/28/00
- 02/29/00
- 03/01/00
- 12/30/00
- 12/31/00
- 01/01/01
- 02/28/01
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Stalking the MBA

Ohio offers a variety of opportunities for physicians who are interested in adding a business degree to their medical training.

(Editor's note: Last month, Ohio Medicine examined the pros and cons of earning an MBA. This month, we present a listing of MBA courses for those who have decided to proceed with courses.)

The opportunities for adding business acumen to medical training are as varied as the specialties of medicine. At one end of the scale are optional courses, offered during the initial four years of medical school. At the other end of the spectrum are residential MBA programs that require the participants to temporarily leave their practice and become full-time students again. In between are many creative and approachable programs that disseminate focused business education.

What follows is a sampling of Ohio and national learning opportunities at three typical levels. Some of these are tailored specifically to physicians and health-care professionals. Others have a high percentage of attendance from among the health-

care professionals.

During training:

• MD/MBA

University of Cincinnati Medical Center.

Medical school students take a hiatus from their training to immerse themselves in a fast-track, one-year MBA program, generally after their third year of medical studies. In its infancy, the program contains standard MBA courses not specifically tailored to medicine, but selected for relevancy.

• Fellowship/MBA

The Ohio State University College of Medicine.

Also in its infancy, this program is integrated into regular fellowship, post-graduate medical training, allowing participants to continue to practice on a limited basis. Courses are both general MBA material, plus some more tailored to medical interests.

MBA or graduate programs:

• MBA

Fisher College of Business, The Ohio State University.

A standard MBA program with strong participation from health-care professionals. Pilot studies in distance

learning formats for the MBA program will likely evolve that option within the near future, providing more flexibility for busy physicians.

• Health Care Executive MBA

Baldwin-Wallace College and Northeastern Ohio University College of Medicine.

Most courses are team taught by members of both faculties in one-and-a-half-day classes, held every other weekend for three semesters. The program aims to help physicians who know that medical practice requires business knowledge and is much more complex than hanging out a shingle.

• Executive MBA in Health Services Management

Olin School of Business, Washington University, St. Louis, Missouri.

Classes meet every other week for 19 months; emphasis is on operating efficiently in a changing environment that requires sound business performance.

• Health Care Executive MBA

University of California, Irvine, California.

Classes meet for three-and-a-half days, once a month for two years. There are three week-long residential

segments in management of complex organizations, federal health-care policy, and executive leadership. Tuition includes the cost of a laptop.

• Graduate program in leadership and management

The Alliance for Medical Management Education, University of Texas at Dallas School of Management and the University of Texas Southwestern Medical Center at Dallas.

A physician-only program designed to provide skills in leadership, understanding the changes in health care, the patient/client service model, organizational strategies, and effective resource management.

• Physician Executive MBA

University of Tennessee, Knoxville, Tennessee.

An innovator in using distance learning combined with short residency periods in a fast-track, one-year program. Physicians only. Emphasizes business fundamentals, management and integrated delivery strategies. Attendees develop their computer skills significantly.

Management programs:

Continued on page 18

Stalking the MBA

Continued from page 17

- Management certificate program
Fisher College of Business, the Ohio State University.

Suggested for those unable to take an extended professional leave and who want to sample MBA-type topics – for example, accounting, marketing, negotiation, information technology, and corporate strategic planning. Fourteen sessions held during three months.

- Certified health-care executive
Franklin University, Columbus, Ohio. Still in the concept stage, the idea would encompass a quasi-parallel track to their regular MBA program, which is very well attended. Most courses would be in modules that could be worth CME credit.

- The business of medicine
Johns Hopkins School of Continuing Studies, Baltimore, Maryland. The four, 10-week modules on managed care, accounting, finance and leadership and organizational behavior are available as a whole curriculum or an individual units. Distance learning using regional Sylvan Learning Centers include Ohio and worldwide locations to present most classes during convenient hours, once a week. Certificate and CME credit available.

- Executive education certificate

program for physicians

Massachusetts Medical Society, the Wharton School of Business. This program is structured as a short series of all-day seminars led by medical industry leaders. The recent series featured programs on financial management, legal and ethical issues, and informational and operational aspects of managed care.

To learn more about these programs, contact the facility that interests you. The OSMA Educational Services Department can also provide you with information on MBA programs. See "Take Action" for how to contact the department. — Yvonne H. Bury

Take Action

The OSMA Educational Services Department is conducting a random survey of members to determine whether or not there is an interest in this type of programming. If you do not receive a survey, but would like to comment on the issue, contact Educational Services at (800) 766-6762, Ext. 6735 or e-mail: education@osma.org. The department can also provide information on MBA programs available in Ohio and elsewhere.

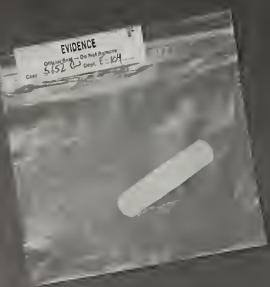


exhibit A:

Adhesive bandage, which plaintiff alleges defendant pulled rapidly from skin, violently tearing three hairs from plaintiff's arm, which resulted in severe shock, trauma, disfigurement, chronic debilitating pain and permanent psychological damage.

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AMA Report

Continued from page 14

collaboration will be diabetes. The PMCC is a joint collaboration with the American Medical Accreditation Program (AMAP), JCAHO and NCQA. The council will work to ensure that measurement-driven assessment processes are efficient, consistent, and useful for the many parties that rely on them to make important decisions about health care. A PMCC Diabetes Clinical Logic Work Group met last month, and work will continue on this project.

- Genetic guidelines
The need for increased emphasis on education and training for genetics/molecular medicine was highlighted in the September 1999 Council on Medical Ethics/Continuing Physician Professional Development report. A spring 1999 survey revealed that current efforts are fragmented, but it's clear that there is a recognition that genetic/molecular medicine will change the way medicine is practiced. The AMA program in genetics will develop appropriate CME activities and other strategies. ■

Your Practice Guide



After an honest attempt to collect overdue bills, a physician may wish to employ the services of a professional collection agency. This may be followed by contact from an attorney, followed by writing off the debt or possibly other "lost steps".

Calm, cool collections

How do you collect what you're owed—and still keep your patient? It's on art say the experts

There's a knack for dealing with medical collections. The idea is to get the overdue payment paid—without alienating the patient.

So delicate and so important is the whole process of collecting that the really successful collections strategies are scripted. There are form letters...form conversations...all with proven track records for use.

Ellen Coolidge, the principal association manager for I.C. System, the OSMA's endorsed cash flow management and debt collection service, suggests the best strategy for overdue payments is to "collect right away, abide by the laws, and know how to do it without losing customers." That means developing communication techniques, effective credit and collection strategies (and personal strategies for those who do the contacting or calling), and effective use of resource materials. It also means learning how to develop scripts that can be used in letters or direct conversations.

"It's very important that those involved with collections understand the mind-set involved, as well as the physician's and patient's rights," Coolidge adds.

Here are steps your practice should take for assuring calm, cool collections. The tips are based on advice from Coolidge and the OSMA legal fact sheet on billing and collection—

1. Establish a collection follow-up policy

For the usual cases of nonpayment, a physician's collection follow-up should do the following:

- Remind the negligent patient of the financial obligation for treatment;
- Determine the specific reason behind nonpayment; and
- Discuss any problem that may be the reason for nonpayment with the patient and work out a solution.

2. Work out a collection timetable

Each medical practice will want to work on its own "collection timetable" to determine what collections steps are taken and when. A typical timetable is as follows:

- Send a billing statement.
- Send a letter reminding the patient the bill is due. "Letters can be short and to the point," says Coolidge, "but they must review the Fair Debt Collection Practice Act (the federal law governing collection practices) and, in certain cases, should state when certain mandates are applicable."
- Call the patient to secure a commitment of payment, to arrange a payment plan, to determine if the patient is able to pay, or to determine if the patient is dissatisfied with care.
- Send a second letter reminding the patient that payment has not been received.
- Call the patient, asking for a definite payment amount and date and

solving any further problems that may be presented.

- Send the patient a final reminder letter with another follow-up call if needed.
- If necessary, turn the account over to a collection agency if payment still has not been received, and there is no known problem.

3.) Set up an "accounts receivable aging record."

Once a collection policy and timetable are established, develop a way of spotting those accounts that are or about to become delinquent. An "accounts receivable aging record" is common because it provides three important pieces of information:

- A patient-by-patient listing of those accounts which require collection follow up.
- An overall picture of the collection system's effectiveness.
- An estimate of the real worth of the accounts receivable.

4.) Start maximizing collections at the beginning

Start at the beginning, when your patient first comes through the door.

- Discuss the costs of medical services and all the possible payment plans with the patient.
 - Establish and address any reason for patients not paying their medical bills.
- Yvonne H. Bury

Toke Action

If you would like a copy of the OSMA legal fact sheet on billing and collection practices, contact the Ohio Medicine reader response line, (800) 766-6762, Ext. 6580, and ask for item #36-99.



Seminars demystify collections

The OSMA, in cooperation with I.C. System, the OSMA's endorsed cash flow management and debt collection services, sponsored two half-day collection seminars last month, in Cincinnati and Dayton. (More seminars will likely be offered in 2000.) The seminars were also co-sponsored by the Ohio Medical Group Management Association.

Doug Evans, OSMA director of membership services, says the seminars "deal with a service that physicians or their office staff need, so they can be in tune with the most current strategies for successful collections." It's one more way the OSMA strives to help members practice in today's challenging managed-care environment.

According to Ellen Coolidge, the principal association manager for I.C. System, the seminars were designed to demystify the collections process. "There is sometimes a difficulty in dealing with money," she says. Seminar attendees are trained to establish an office collections policy within the scope of their environment, and within the scope of their owners' perspective. "Yet too often, such a policy isn't firmly in place," Coolidge says.

The training program includes videotaped examples of acted-out, factually-based situations, typical of what happens with a noncompliant person who owes the practice a sum of money. The role play has a goal of developing effective strategies. I.C. System trains seminar attendees in their way to diffuse the angry patient and encourage two-way communications again. There are also sections of the seminar that deal with telephone contact. Ultimately, says Coolidge, the goal is to communicate the situation's urgency, and that enforcement could be enacted.

If you're interested in upcoming collections strategies seminars, please contact Doug Evans at (800) 766-6762, Ext. 6774. — Yvonne H. Bury

Costly lookbacks

Carriers are becoming more aggressive in searching for errors and making you pay.

If the Internal Revenue Service realizes you've paid too little in taxes, it wants you to pony up what you allegedly owe — even if the mistake goes back five or six years. Now insurance companies, and in some instances the U.S. Office of Personnel and Management, are taking on the same philosophy, says Todd Baker, OSMA director of Medical Economics and Advocacy. "The carriers are hiring companies to aggressively go back over several years and look at claims that they can say were paid erroneously and collect on those money."

"Lookbacks," as they're called, do not appear to be fraudulent, Baker says, but rather are intended to correct carriers' mistakes. "They're saying, we've been aggressive at trying to manage the care up front, but maybe some things have slipped through the cracks that we really shouldn't have paid for, so let's go back and look at those."

Who's collecting?

Often it isn't the carrier but a collection agency that contacts a physician for repayment. Some physicians have reported communications from

agencies that make no initial mention of a carrier, Baker says, and only after the physician denies any obligation to that agency does the agency admit its role as a contractor to the insurance company. "There are some communications getting to doctors where there's absolutely no mention of the original carrier anywhere in the communication," Baker says.

There are also reports of agents trying to collect against physicians for carriers they don't even have contracts with, says Jennifer Hyle of the

OSMA Department of Ombudsman Services. And if you do have a relationship with the carrier, adds Hyle, "you may not have a contract for that particular line of business."

Some such collection attempts are the product of overzealous lookback policies, but some are simply bookkeeping errors, so be sure to check lookbacks against your own billing charges and documentation, Hyle says. "Make sure that those services were actually done and they were all documented. The physician needs to challenge the

audit with an appeal and fight aggressively with documentation from the chart that supports the services."

OSMA needs examples

Regardless of who contacts you, get in touch with your legal counsel and with the OSMA. "We are anticipating introducing legislation next year to put a time frame on how far back they can go," Baker says. "What we're hoping to do is put a cap on it, say, of a year."

"Even if you end up having to pay," Baker says, "we really want to know about it, because we want to use that as a kind of fuel for a legislative initiative."

Hyle is collecting information on physicians who have been subject to lookbacks. "Without any of this information," she says, "it's hard for us to do anything legislatively." — Jan Leibovitz Alloy

Take Action

For more information, or if you've been the subject of a lookback, contact Jennifer Hyle, OSMA Department of Ombudsman Services (800) 766-6762, Ext. 6757.

Do you have to pay?

If you find that you did, indeed, provide the service you're contacted about, are you obligated to pay? It depends on who contacts you, says Todd Baker, director, OSMA Medical Economics and Advocacy.

■ If it's a collection agency with no carrier affiliation that claims to be working on behalf of a carrier, unless you have a contract with that insurance company, you probably don't have to pay.

■ If it's an agency affiliated with a carrier and you've been contracted to that carrier, you may have to pay.

■ If the carrier itself contacts you, you may have to pay, especially if you provided the service only a year or two in the past.

Before making any payments, contact your legal counsel, the OSMA Department of Ombudsman Services and aggressively appeal every case with the insurance company.

If you have questions about your payback obligations, contact the OSMA Department of Ombudsman Services, (800) 766-6762, Ext. 6757.

Medicare claim denied? Check your CLIA certificate

The 24-month grace period to make payment without expiration has been shortened to six.

If you're in the habit of waiting a couple of years to renew your CLIA certificate, here's a word of advice: pay attention to your certificate's expiration date and renew it quickly, or suffer the consequences — denied Medicare claims.

The 24-month grace period to make payment on your CLIA certifi-

cate without expiration has been shortened recently to just six. However, you will receive notice that your certificate is about to expire. Six months before the expiration date, you'll receive a bill

from the Ohio Department of Health for your CLIA certificate renewal. If



that bill isn't paid, you'll receive a second notice two months later. Let the bill continue to lapse and you'll be sent a final notice. Six months later, your CLIA files will show an expiration date and Medicare claims will be denied.

Nationwide says it cannot maintain the CLIA files, only the Ohio Department of Health, so if your claims are de-

nied for an expired CLIA certificate, you should contact the state health department as soon as possible. Once the CLIA files are updated, you may re-submit the claims to Medicare.

On the subject of CLIA, don't forget to look at the September issue of the Medicare newsletter (on their Web site: www.nationwidemedicare.com/medicare%20newsletters/sept99.htm) for new tests that have been granted waived status under CLIA. ■

MULTI-SPECIALTY GROUP PRACTICE IN EASTERN CLEVELAND SUBURBS...

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Duty to warn

Ohio's new "duty to warn" law establishes a mental health professional's duty to warn potential victims of a patient's violent threats while avoiding liability. For the OSMA's legal summary of the new law, contact the *Ohio Medicine* reader response line, (800) 766-6762, Ext. 6580, and ask for item #37-99.

Drug sample "law" clarified

The laws related to drug samples says certain records must be maintained. It does not mandate how this is to be accomplished.

The OSMA has received several calls in response to the article, "Managing Drug Samples," that ran in the "Practice Tips" section of the September 1999 issue of *Ohio Medicine*. Specifically, callers are asking for the actual law governing tracking of drug samples.

The laws related to drug samples address the distribution of samples from manufacturers to distributors, and specify that certain records of receipt must be maintained. However, the further implication is that, should the government need to track what has happened to a sample drug, the physician who has received the drug must be able to account



Ohio Medicine

A publication of the Ohio State Medical Association

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Ohio Medicine (ISSN 0892-2454/USPS 405-200) is published monthly for \$40 a year by the Ohio State Medical Association, 3401 Mill Run Drive, Hilliard, Ohio 43026. Periodicals postage paid at Hilliard, Ohio and at additional mailing offices. POSTMASTER: Please send address changes to *Ohio Medicine*, 3401 Mill Run Drive, Hilliard, Ohio 43026.

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for all drug samples received.

The law does not mandate how this is to be accomplished. What *Ohio Medicine* provided is the perspective of both the pharmacy and the medical board as to recommended methods for tracking drug samples. Once a physician office has obtained drug samples, the management of those samples is largely an issue of risk management. What protocols and record-keeping systems make sense in order to ensure only authorized personnel have access to samples, and that the responsible physicians maintain accountability for receipt and disposition of samples? The physician is ultimately accountable for any loss or misuse of drug samples. ■

Colleagues

Newsmakers

CATHERINE BISHOP, DO, Chillicothe, OH, was one of four district directors elected by the Ohio Academy of Family Physicians (OAFP). Dr. Bishop will serve a two-year term, leading and monitoring family practice activity at a local level, and also serve as a member of the organization's board of directors.

JANET BORCHERDING, MD, Cincinnati, recently received a Leadership Award from Cancer Family Care. The award was presented during the association's 23rd annual meeting.

KEITH CLARK, MD, Cincinnati, received the Barbara Rose Lange Award from CFC during Cancer Family

Care's annual meeting. Dr. Clark received this award for his exceptional contributions as CFC board member.

BRETT M. COLDIRON, MD, Cincinnati, was installed as president of the Ohio Dermatological Association at the ODA's 16th annual meeting.



Brett M.
Coldiron, MD

LYNN GLEICH, MD, Cincinnati, associate professor of otolaryngology – head and neck surgery at the University of Cincinnati Medical Center, received a \$70,000 grant for his research on "Gene Therapy in Head and Neck Cancer." The grant was jointly given by the American Head and Neck Society and the American

Society of Otolaryngology – Head and Neck Surgery.

PETER LAU, MD, Toledo, OH, CEO of the American Red Cross Biomedical Services, Western Lake Erie Region, was the recipient of the annual President's Fund Award for Cultural Diversity Ambassadors at the Red Cross' annual meeting. He was recognized for contributions toward achieving a diverse and inclusive organization.

DANIEL P. MCKELLAR, MD, Beavercreek, OH, recently received a three-year appointment as cancer liaison physician for the Hospital Cancer Program at Good Samaritan Hospital and Health Center. The Cancer Liaison Program is an integral part of the Commission on Cancer of the American College of Surgeons.

Portrait

During the Cold War, Cleveland neurosurgeon Robert J. White, MD, was invited to the Soviet Union to lecture on brain research. Today, he is a newly elected member of both the Russian and Ukrainian Academies of Medical Science.

Robert J. White, MD, has been something of a pioneer in researching the human brain. His research on monkeys in the 1960s and his technique for cooling the brain (a technique that later proved applicable in vascular surgery) has taken him through numerous medical, political and religious realms.

He was first invited to the Soviet Union during the Cold War, where he lectured on the brain research he was conducting. From 1966 to the early 1990s, Dr. White reviewed medical cases and lab work, as well as demonstrated operating techniques in the former Soviet Union. "Conditions, in terms of sanitation and drug and instru-

mentation availability were very primitive during the communist regime. Since the change in government, it's even worse," says Dr. White. Russia is trying to model its health-care delivery system after the United States, yet lacks a solid economic base to fund a free enterprise system.

In 1970, as brain death was becoming a controversial issue for physicians and theologians alike, not only in the United States and Russia but all over the world, he met with Pope Paul VI to discuss developments in the field of brain research. Dr. White contributed to the bioethical commission formed by the Vatican to address the religious and medical ethics behind ending a human life. He continued these discussions throughout his medical career, and still meets yearly with Pope John Paul II.

Dr. White's forward-thinking research ideas continue. Recently, he published an article in *Scientific American* on a surgical procedure he calls



Robert J. White
MD, PhD

"total body transfer." A quadriplegic, whose body organs are maintained through the aid of a respirator, could die of multiple organ failure. Yet, technology exists that would enable surgeons to retain the brain within the skull and transfer the head to a new, healthy body. As no procedure exists, yet, to repair a severe spinal cord, the patient would still be immobile. While Dr. White sees it as a life-saving operation, many physicians and theologians are divided on moral and ethical issues as debates over quality of life and the mind, body, soul connection continue.

Now retired, Dr. White is still a professor of neurological surgery at Case Western Reserve University. He lectures both at home and abroad, and writes a medical column for the *Sun Press*. And earlier this year, some 30 years after his first visit to the former Soviet Union, the Russian and Ukraine scientific communities finally recognized his achievements by electing him into their Academies of Medical Science – an accomplishment few Americans or other non-Russians achieve. – Pam Willits

Obituaries

ALVIN L. BERMAN, MD, St. Ridgeville, OH, Northwestern University Medicine School, Chicago, 1942; age 86; died Oct. 3, 1999.

LUBIANA BHATTI, MD, St. Clairsville, OH, University of Maiduguri, Fac of Medicine, Maiduguri, Borno State, Nigeria, 1983; age 39; died Sept. 4, 1999.

JOSEPH J. CAMPOLITO, MD, Youngstown, OH, Indiana University School of Medicine, Indianapolis, 1948; age 76; died Oct. 9, 1999.

GEORGE R. DAKOSKE, MD, Kettering, OH, Wayne State University School of Medicine, Detroit, 1960; age 65; died Oct. 22, 1999.

GEORGE J. DAVID, MD, Akron, Case Western Reserve University, School of Medicine, Cleveland, 1967; age 63; died Sept. 28, 1999.

DAVID S. GREENBERG, MD, Hallandale, FL, Ohio State University, College of Medicine, Columbus, OH 1930; age 94; died Oct. 12, 1999.

STEPHEN E. HETEY, MD, Akron, OH, Orvosi Fakultas, Tudomanyegyetem, Debrecen, Hungary, 1943; age 82; died Oct. 22, 1999.

RICHARD P. MOON, MD, Dayton, Ohio State University, School of Medicine, Columbus, OH, 1943; age 84; died Sept. 30, 1999.

WILLIAM E. RUSSELL, MD, Genoa, OH, University of Michigan Medical School, Ann Arbor, MI, 1934; age 91; died Oct. 21, 1999.

THOMAS B. SHIPLEY, MD, North Canton, OH, University of Rochester, School of Medicine-Dentistry, Rochester, NY, 1942; age 83; died Oct. 8, 1999.

MICHAEL P. SPADAFORA, MD, Cincinnati, University of Cincinnati, College of Medicine, Cincinnati, 1984; age 46; died Oct. 24, 1999.

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